USAREUR Suicide Surveillance Project:

Data Summary and Program Evaluation

Carol A. Dolan, Ph.D., Erica D. Schroeder, M.A, Kathleen M. Wright, Ph.D., CPT Jeffrey L. Thomas, Ph.D., & MAJ James W. Ness, Ph.D.

US Army Medical Research Unit-Europe

Heidelberg, Germany

Executive Summary

In FY 2000, the Commanding General of USAREUR /7th Army commissioned a Suicide Prevention Task Force (SPTF) to investigate and analyze data on suicide events in USAREUR. As part of the SPTF, the US Army Medical Research Unit-Europe conducted a study that examined suicide event data, developed a surveillance form to track suicide events, evaluated the benefits and costs of implementing a surveillance system, and provided ongoing feedback to the SPTF on the status of suicide events in USAREUR. A review of archived medical records covering a two-year period from May 1999 through May 2001 formed the baseline for comparison with the real-time events reported by clinicians for the one-year period of study conducted from June 2001 through June 2002. These assessments resulted in revisions to the surveillance form and the eventual fielding of the AMEDD Suicide Event Report (ASER). Interviews with clinical providers who participated in the program evaluation assessed the costs and benefits of the surveillance system and detailed recommendations for improving the program. The development of the ASER and the surveillance program, and its subsequent evaluation, supported Science and Technology Objective W: Enhancing Psychological Resilience to Prevent Psychiatric Casualties, a program of research within the US Army Medical Research and Materiel Command's Research Area and Directorate III.

This report is divided into three sections. The first section discusses the procedures for developing and evaluating a surveillance system and includes a review of the literature on risk factors for suicide events in the military. The identified factors overlap those found in civilian populations. However, there are risk factors that may be unique to the military and that should be considered when assessing suicide events in this population, such as age, gender, and military deployment. For the USAREUR surveillance program, relatively consistent risk factors were found for both the archived medical record data, as well as for the data collected in real-time from clinical providers.

The second section of the report describes the data collection process and findings. There were seven completed suicides in USAREUR for the three-year period from May 1999 to June 2002. There were 221 non-fatal suicide events collected from archived records during the 25 months of baseline surveillance and 161 suicide events reported by clinical providers for the 13 months of on-going surveillance. Results from the two data collections were comparable and the monthly number of suicide events over the three-year period of surveillance was relatively stable, with an average of 8.8 events per month reported for the baseline period and 12.4 events per month for the on-going surveillance. Differences in number of events may be due to the more inclusive method used in the on-going surveillance in which all USAREUR clinics were to report suicide events in contrast to the baseline data collected from archived medical records.

Results also indicated that the risk factor profile for soldiers involved in suicide events was similar to risk factor profiles found in previous military studies, and generally consistent with the civilian literature. Soldiers at risk for suicide events tended to be junior enlisted in rank, had served overseas less than a year, reported relationship and work problems occurring within three-months of the event, resided alone, failed to communicate intent, and had no prior history of suicide attempts. The event typically occurred in garrison and the most common method used

was overdose. The most frequently occurring diagnoses for those at risk included alcohol abuse, adjustment, mood, or personality disorders.

Using CDC program evaluation guidelines, the third section of the report evaluated the surveillance program from the perspective of the clinical provider, compared the clinical provider responses to the number of suicide events determined by records review, and lastly, summarized the strengths and weaknesses of the suicide surveillance program. The program evaluation covered the one-year period during the on-going surveillance data collection. The first six months of the surveillance program indicated a high response rate by providers; the second six months showed a drop in response rate. Possible reasons for this decrease include the events of September 11, 2001 and participation in Operation Enduring Freedom (OEF) that started in October 2001. As a result of these events, hospital and clinical personnel were deployed, there were added requirements in USAREUR for force protection, and increased hospital admissions related to OEF casualties. The amount of time and lack of personnel required to complete the surveillance form were the primary challenges cited by clinical providers as barriers to implementation. Additional comments on the surveillance form, the value of a suicide surveillance system, and suggestions for successful implementation of a surveillance program are summarized.

Section One: Introduction & Background

Introduction

The U.S. Army is implementing an electronic surveillance system for suicide-related events. An evaluation of the U.S. Army Europe (USAREUR) suicide surveillance program conducted by the U.S. Army Medical Research Unit-Europe (USAMRU-E) provides valuable lessons learned and facilitates the design and implementation of an Army-wide suicide surveillance program. The program evaluation is based on the collection of data on suicide events within USAREUR over a three year period consisting of: (a) twenty-five months of pre-surveillance baseline data collected from archived medical records covering the period from May 1999 through May 2001; and (b) thirteen-months of surveillance data collected from clinical providers from June 2001 through June 2002.

This report has three sections. Section One provides an introduction to the scope of the problem and describes the objectives and planning for the USAREUR Suicide Events Surveillance System by summarizing recent suicide data and reviewing the military literature on the risk factors associated with suicide and suicide attempts. In addition, the rationale and procedures for developing and evaluating a surveillance system will be discussed. In Section Two, data collected during the USAREUR suicide events surveillance program will be presented and discussed. In Section Three, the program evaluation of the surveillance system will be summarized, to include the development and revision of the surveillance form, results from interviews with clinical providers who participated in the program, and an assessment of the response rate during the surveillance data collection period.

Scope of the Problem: Suicide statistics

Completed suicides in 2001 accounted for 30,622 American deaths, a rate of 10.7 per 100,000 (Center for Disease Control [CDC], 2003). Suicide continues to be one of the top 15 leading causes of death in the United States. Adolescents and young adults die more often from accidents (unintentional injury), homicide, and suicide then any other ailment or injury. Males and males with access to firearms complete suicide more often than females, while females tend to attempt suicide more often than males. Table 1 in Appendix A lists some civilian demographics and risk factors for suicide completions and suicide attempts. The military also faces the problem of suicide events. Epidemiological data have shown that suicide was the third leading cause of death in the military for the years 1980 through 2002 (Washington Headquarters Services, 2003).

Risk factors for suicide and suicide attempts

Beyond basic suicide demographics, risk factors are often examined in suicide studies. Studies have found risk factors such as unemployment, lack of medical care, severe physical impairment, homosexual life style, depression, and psychotic symptoms as contributing factors to suicide behavior (Plutchik, 1995). The military population risk factors differ somewhat in that service personnel are employed, have access to medical care, are physically fit, and tend to have a support network through work. Nonetheless, suicide continues to be a threat to the military population as was noted above. Figure 1 in Appendix B contains a comparison of civilian and military completed suicide rates from 1996-2001.

Although the military and civilian populations differ, there are several common risk factors that include relationship and work-related problems, history of childhood physical or sexual abuse, past history of suicide attempts, depression, substance abuse, and frequent relocation. Although there are

risk factors common to both populations, the military population is distinctive enough to warrant examination of risk factors in a military context.

Military population risk factors

Relationship problems were found to be a risk factor for suicide behaviors in both civilian and military populations. Research conducted across the military services has consistently found relationship problems to be a risk factor for suicide behavior (e.g., U.S. Navy and Marine suicide completions, Dennett & Howard, 1988; U.S.A.F., Stall & Hughes, 2002). Within the U.S. Army, relationship problems have been identified as the number one existing problem prior to suicide in 67.6% of the cases (Rothberg, Fagan, & Shaw, 1990), a finding consistent with an earlier study of US Army suicide completions assessed over a period of seven years (Rothberg & Jones, 1987).

Work problems have been cited as risk factors for suicide events in the civilian literature. Work problems in the military population were also identified in two studies looking at attempts and completions (Holmes, Lall, Mateczun, & Wilcove, 1998; Staal & Hughes, 2001), and in three epidemiological studies: two that address suicide completions among active duty Army (Rothberg et al., 1990; Rothberg & Jones, 1987) and one comparing Marine and Navy suicide completions (Dennett & Howard, 1988).

A history of childhood abuse has been identified as a risk factor in civilian studies as well (Felitti et al., 1998; Fergusson, Woodward, & Horwood, 2000; Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001). However, very few studies of military populations have addressed childhood abuse as a risk factor for suicide. One exception was a study conducted in the Marine Corps that evaluated 137 variables using multiple regression and found a history of abuse, neglect, and rejection were strong predictors of suicide (Holmes et al., 1998).

Similar to studies of childhood abuse, few military studies address past history of suicide attempts as a risk factor for future attempts and completions. The two military studies that examined this risk factor found conflicting results (Staal & Hughes, 2001; Wasileski & Kelly, 1982). One study found 42% of the suicide attempt sample had attempted suicide prior to entering the Marine Corps (Wasileski & Kelly). On the other hand, Staal and Hughes (2001), in a study of Air Force service members, found the majority of those who completed and attempted suicide did not have a history of suicide attempts. However, the time period measured was for one-year prior to the suicide event and not suicide behavior over a lifetime, as most civilian population studies assess when investigating prior attempts as a risk factor (Brown, Beck, Steer, & Grisham, 2000; Hawton, Fagg, Platt, & Hawkins, 1993; Iribarren, Sidney, Jacobs, & Weisner, 2000; Lewinsohn, Rohde, & Seeley, 1994; Mann, 2002; Plutchik, 1995; Safer, 1997; Welch, 2001).

Depression has long been linked with suicide behavior and considerable research has addressed this risk factor in civilian populations (Mann, 2002; Welch, 2001; Brown, et al., 2000; Plutchik, 2000; Felitti, et al., 1998; Lewinsohn, Rohde, Seeley, & Baldwin, 2001; Kessler, Borges, & Walters, 1999). Similar findings appear in studies of the military. For example, in a three-year study that looked at suicide ideation, attempts, and multiple attempts in U.S. Army soldiers, depression was one of three disorders most frequently diagnosed. In addition, those who had multiple attempts were more severely depressed than the other two groups (Rudd, Joiner, & Rajab, 1996). Depression was also found to be a risk factor in two other studies addressing attempts and completions (Staal & Hughes, 2001; Wasileski & Kelly, 1982). One study of Marine recruits found those who attempted suicide reported more negative affect on the mood questionnaire than the control group or training/discipline problem group (Wasileski & Kelly). In a more recent study of USAF service members who attempted or completed

suicide, a mood disorder was the predominant diagnosis for both attempts and completions (Staal & Hughes).

Substance abuse, particularly alcohol abuse has long been associated with suicide events in the civilian population (Lester, 2000; Plutchik, 1995; Rosow, Romelsjo, & Lifeman, 1999; Tanney, 2000; Welch, 2001). In the military population, alcohol abuse has also been found as a risk factor for suicide attempts. In a three-year study that looked at Army personnel with suicide ideation or who had attempted suicide, alcohol abuse was one of three disorders most frequently diagnosed (Rudd, Joiner et al., 1996; Rudd, Rajab et al., 1996). In a study that compared a group of Marines who had exhibited suicide behavior to a group without psychiatric problems or suicide history, alcohol abuse was one of seven risk factors discovered using multiple regression analysis (Holmes et al., 1998). Alcohol abuse was also found more frequently for USAF personnel who had attempted suicide than for those who had completed suicide (Staal & Hughes 2002).

One factor that is more unique to the military than to the civilian population is the experience of frequent moves and transitions. Typically, in the military, service members change jobs and locations every two or three years. This is less often the case in the civilian population. Changes in living conditions and specific characteristics of frequent moves were found to relate to suicide behavior over a three-year period in a U.S. Army study of transition and suicide completions (Rothberg, 1991). When older age groups were compared to 17-21 year olds, a significant correlation was found between the frequency of service member moves and completed suicide for the 17-21 year old age group. These findings are consistent with a civilian study that examined the relationship between frequent moves and the severity of suicide attempts finding that multiple moves within a 12-month period was a more significant risk factor for suicide attempts assessed as medical severe than other risk factors such as age, gender, alcohol abuse, or depression (Potter, et al., 2001).

Risk factor differences in the military and civilian populations

Risk factors that may differ between military and civilian populations include gender, military deployment, and age. In the civilian population, females more often than males use low lethality when attempting suicide and males complete suicide more often. Koshes and Rothberg (1992) found a gender difference, compared to civilian population samples, in a study of active duty Army trainees. In their study, male trainees predominantly attempted suicide and 37% of service personnel treated at the Community Mental Health Service (CMHS) used methods of self-harm that were low in lethality and high in rescuability. According to the authors, the typical service member who attempted suicide was an E-1, male, single, white, 20 year old, who overdosed on pills, had problems adjusting to the military or being away from home, and used the suicide attempt as a means to "escape from psychic discomfort" (Koshes & Rothberg, p. 352). These findings are comparable to characteristics of male Marine recruits who attempted suicide; for example, these recruits typically overdosed on pills, had unrealistic expectations or reasons for joining the military, experienced boot camp as extremely stressful, and used the attempt "to effect release from what they perceive to be an intolerable situation" (Wasileski & Kelly, 1982, p. 829).

The military work environment and its requirements may differ from the work problems cited in studies of civilian populations. Particular risk factors in the military could include lack of unit support and problems adjusting to the military lifestyle (Koshes & Rothberg, 1992). In addition, part of adjusting to the military environment may involve experiences relating to deployment. Koshes and Rothberg found in their study of service members at an Army training post that the highest rate of Army suicide attempts and hospitalizations occurred during Operation Desert Storm in February 1991, and the second highest rate took place just after Operation Just Cause (OJC) in February 1990.

The final difference to be addressed between military and civilian populations is the age of those who complete suicide. The civilian age group with the highest rate of suicide completions starts at 65-years of age and increases as one grows older (CDC, 2002b, 2003). In the military, age distribution is heavily skewed to younger age groups. Staal and Hughes (2001) found that in the USAF the predominant age group for suicide completions was 35-years or older. In the US Army, for the two-year period of 1985-1986, the suicide completion rate of 24.5 /100,000 for 45-65 year olds was higher than the civilian population rates of 15.5 and 16.3 for the same time period (Rothberg et al., 1990). Thus, there is a general trend that is consistent between the military and civilian studies: the older one is, the more at risk for suicide completions they are. However, in a more extensive study of suicide completions across a 13-year period from 1980-1992 for all military services, the age group with the highest rate of suicide completion was 17-24 years (Helmkamp, 1995). For suicide attempts, individuals in their 20s are at highest risk in both the military population (Koshes & Rothberg, 1992; Rudd, Rajab et al., 1996; Staal & Hughes, 2001) and the civilian population (Maris, Berman, Silverman, & Nisbet, 2000).

Many, but certainly not all, of the risk factors surrounding suicide attempts are similar to the risk factors associated with completions, and there are factors that may be unique to the military environment that should be assessed. Accurate knowledge of risk factors through effective suicide surveillance would allow for better prevention efforts.

Health Behavior Surveillance

Review of the literature

The basic philosophy of health behavior surveillance systems is to collect data on actual behaviors, rather than on attitudes or knowledge for the planning, initiation, support and evaluation of health promotion and disease prevention programs. Accurate knowledge is fundamental to prevention efforts in two key ways. First, information about incidence and prevalence can provide a determination of prevention need within the target population. And second, surveillance data can help evaluate the impact of prevention efforts aimed at the target population.

The Behavioral Risk Factor Surveillance System (BRFSS) is the CDC's nationwide data collection system that tracks personal health behaviors that play a major role in premature morbidity and mortality (Figgs et al., 2000). This system provides information to state health agencies that in turn have the primary role of targeting resources to reduce behavioral risks and their consequent illnesses. Examples of uses of BRFSS data include the following: (1) educate policymakers, providers, and consumers on the extent and distribution of health risks in the population; (2) develop comprehensive computerized databases of health status indicators; (3) assist public health programs in evaluating the success of interventions, including tobacco control, adult immunization, and teen pregnancy prevention; (4) assist managed care organizations in identifying levels of service utilization and behavioral risks among members; (5) and provide information to insurers, medical care providers, and community health agencies in order to target interventions in the community.

The Youth Risk Behavior Surveillance System (YRBSS) focuses on adolescents and young adults (range 13-20 years, average 16.8 years) in order to determine the prevalence and age of initiation of health risk behaviors, to assess whether health risk behaviors increase, decrease, or remain the same over time, to examine the co-occurrence of health risk behaviors among young people, and to provide

comparable national, state, and local data (CDC, 2002a & 2002c). YRBSS data has been used to implement or modify programs to address the behaviors of young people in a specific health area, to set prevention program goals and objectives and monitor the progress toward those goals, to create awareness of the extent of risk behaviors among young people, to promote state-level changes that support specific health education curricula and coordinated school health programs, and to seek funding from federal, state, and private sources by demonstrating need. In a report published in 1999 based on 1998 data, YRBSS found that 25% of US high school students had seriously considered suicide, 20% had made a specific suicide plan, and 15.7% had attempted suicide that required medical treatment (CDC, 2002a & 2002c).

Suicide surveillance

While systems such as the BRFSS and the YRBSS are excellent examples of national surveillance systems that focus on health behavior, there are few reports describing an effective system that tracks suicide events in larger populations on a real-time basis. Examples of the potential benefits and uses of such systems are discussed in several reports describing suicide prevention. For example, the Indian Health service developed a suicide surveillance system in 1988 which focused its efforts on a small but vulnerable population of Western Athabaskan American Indians in New Mexico (CDC, 1999). Since a suicide prevention program based in part on surveillance data was implemented in 1990, there has been a substantial decrease in suicidal acts among tribe members aged 15-19 years.

The Washington State Department of Health has developed a comprehensive Youth Suicide Prevention Plan that does not collect surveillance data, but it acknowledges that such a system would be extremely useful (Washington State Department of Health, 1995). The USAF has used retrospective data, not ongoing surveillance per se, to develop a database of suicides and suicide attempts among

members of its organization, and has used the data to develop a model to predict suicide (Staal & Hughes, 2002).

Data collected for specific populations can lead to the establishment of local programs that are more effective. Many risk factors associated with suicide in the general population are the same for US military personnel, however there are several key factors are unique to the military community, particularly for those stationed overseas that may indicate the need for a local program. The need for suicide surveillance in US Army, Europe (USAREUR) is clear, and the development of an appropriate system for collecting data is the challenge.

Developing a (suicide event) surveillance system

In order to develop an accurate and effective surveillance system, several steps need to be undertaken (CDC, 1988 & 2001). First, the public health importance of the event needs to be determined, defined and described, to include information about total number of cases, incidence, prevalence, and preventability. Second, a thorough description of the system is needed, to include a statement of the objectives of the system, and a case definition of the health event. Third, the actual operation of the system and its components must be clearly described. This would include information about the population under surveillance, personnel responsible for providing the information, the variables included in data collection, the time period of the data collection, the procedures for data transfer, storage and analysis, and the plan for reporting results of the data collection. Fourth, the level of usefulness of the surveillance system needs to be discussed in terms of what will be done with the data from the surveillance system, and who will use the data to make decisions and take actions.

In the USAREUR suicide event surveillance system, several of these steps were discussed and determined in the planning phases of the program, and prior to start of the data collection. As noted in an earlier section of this report, the occurrence of suicide events is of importance for the civilian health

community and for the military. The incidence of suicide events in USAREUR was viewed with extreme concern, leading to the development of the Suicide Prevention Task Force, and the plan for a data collection system that could help understand and potentially prevent the problem. Case definitions, data collection procedures and personnel assignments were described, and directives provided. Plans to use the data for interventions and prevention were discussed.

Evaluation of the program focused on the extent to which these four steps were followed and the degree to which the plan for surveillance actually yielded accurate and useful information. In addition, several system attributes were also evaluated – simplicity, flexibility, acceptability, sensitivity, representativeness and timeliness. Simplicity refers to both its structure and ease of operation. The surveillance system should be as simple as possible while still meeting its objectives. Flexibility is the extent to which the system can adapt to changing information needs or operating conditions with little additional cost in time, personnel, or allocated funds. Flexible systems can accommodate, for example, new diseases and health conditions, changes in case definitions, and variations in reporting sources. Acceptability involves the level of willingness of persons on whom the system depends to provide accurate, consistent, complete, and timely data. The sensitivity of the system describes its ability to detect the target health behavior or outcome, and its ability to detect epidemics. A system's representativeness refers to how accurately it describes both the occurrence of a health event over time and its distribution in the population by place and person. Timeliness refers to the speed between steps in the data collection, and depends on need for immediate control vs long term planning (see Appendix C for CDC guidelines).

The USAREUR Suicide Event Surveillance System faced many challenges. For instance, determination of a suicide event can be problematic, in terms of discriminating between gestures such as self-mutilation behavior and more serious events. In addition, many suicide attempts would not be

captured by a surveillance system such as this unless the individual seeks medical care. It was clear to the task force members and researchers that the procedures of data collection may impose added effort to a hard working and busy health care community. Despite the challenges, this suicide surveillance system was initiated with the goal of providing accurate, timely information on suicide events that would ultimately assist in patient care in USAREUR.

Section Two: The USAREUR Suicide Surveillance Program

This section of the report describes the 2 primary data collection components of the project. First, the process of data collection and results of the 25-months baseline of USAREUR suicide events, along with associated risk and context factors and demographics, are presented in order to serve as a basis for comparison to the new data collection (surveillance) system. Second, methods and results of the 13-months of suicide event surveillance are described. The program timeline is described in Table 2, Appendix A.

Background: The Suicide Surveillance Program in USAREUR

In FY00, the Commanding General of USAREUR/7th Army commissioned a Suicide Prevention Task Force. At the request of the USAREUR Command Surgeon, the US Army Medical Research Unit-Europe (USAMRU-E) became a member of this Task Force responsible for analyzing USAREUR data on suicide events. In June 2001, a suicide surveillance form was fielded by the USAREUR Command Surgeon to track suicide events in real-time. All USAREUR medical assets were to inform the European Regional Medical Command Social Work Services within 24 hours of such events. Within 72 hours, the surveillance forms were to be completed by clinical providers and sent to the USAMRU-E as a data repository. USAMRU-E's key role was to provide monthly updates through the Suicide Prevention Task Force to USAREUR leadership, and briefings to the USAREUR leadership on trends and risk factors for suicide events. This constituted the surveillance (real-time) component of the study. In addition, USAMRU-E researchers reviewed inpatient records in USAREUR from May 1999-2001. This constituted the pre-surveillance baseline component of the study. USAMRU-E developed and presented a briefing that covered the pre-surveillance data and the first six months of the surveillance phase. This brief was prepared for and presented to the USAREUR Command Surgeon in February 2002 (See Appendix I).

Pre-surveillance data collection

Methods

To obtain baseline and trend data, USAMRU-E collected information on suicide events occurring from May 1999 through May 2001. This pre-surveillance baseline part of the project was conducted from June through August 2001 and began with the review of archived intake logs from inpatient psychiatry at Landstuhl Regional Medical Center (LRMC). In addition, the Medical Records Consultant located at Landstuhl provided a list of records identified with a trauma code for intentionally self-inflicted injury. Using these two methods, in-patient records were selected for review to determine whether a suicide event had occurred. A total of 561 records were selected, including 134 records from the hospital trauma code and 427 records from the inpatient psychiatry intake logs. Results from the review identified 345 records containing suicide events (3 completions, 15 self-mutilations, and 327 attempts), 204 records were determined not to include self-injurious events, and 12 records were not available for review.

The data collection form used to summarize suicide event information was based on a modified version of the US Air Force's existing suicide investigation form, Suicide Event Surveillance System (SESS) Investigation Worksheet, AF Form 4273 (USAF, 2001). USAMRU-E researchers completed the suicide surveillance form based on information contained in the medical records (see Appendix D). Subsequent revisions to the form resulted from this phase of data collection. That is, through the review of inpatient records for these cases, researchers were able to add valuable data points that were not included on the original form. A revised form (see Appendix E) that included these additional data points was used for the review of records from 1999, conducted at Landstuhl's Medical Records Storage Unit in Bensheim, Germany. The pre-surveillance baseline portion of the data collection was completed in July 2001. In total, 350 completed surveillance forms were included in the final analysis for the pre-

surveillance baseline data. The revised form that developed from the baseline review was fielded in August 2001 to USAREUR clinical providers, thus extending the inclusion of more robust data points for the surveillance data collection.

Results: Suicide Event Frequency, Demographics, and Risk Factors

The following sections summarize the findings from this baseline assessment of suicide events in USAREUR.

During the pre-surveillance period, May 1999 through May 2001, a total of 221 non-fatal self-injurious events were found during the record review data collection. Frequency data by month are presented in Figure 2 in Appendix B, followed by monthly incidence rates in Figure 3 in Appendix B. Rates were calculated by using estimated troop strength figures provided by 1st PERSCOM, the personnel command for USAREUR. Given that troop strength figures were relatively consistent for the time period of focus, both charts appear comparable. For the pre-surveillance phase, a total of 221 events were recorded, with a monthly average of 8.84 (Figure 2, Appendix B). Crude incidence rates, based on troop strength indicate an average rate of 14 per 100,000 (Figure 3, Appendix B).

Demographics on age, marital status and ethnicity are comparable to general US population statistics (Table 3, Appendix A). As reported in Figure 4 in Appendix B, the rates of non-fatal self-injurious events for males and females appears different for this sample as compared to civilian population statistics. The probability of a non-fatal self-injurious incident for female soldiers in USAREUR is 2 times that of males. In the general population, the probability of a nonfatal incident for women is 3 to 4 times that of men (Figure 4, Appendix B). Incidence by military rank indicates a higher incidence rates for junior-enlisted soldiers with statistical break at E4 where lower ranks show higher than expected rates and ranks above E4 show lower than expected rates. The decreasing incidence trend

across rank for enlisted soldiers is consistent with age-related trends reported in the literature (Figure 5, Appendix B).

In addition to frequency and demographic data, we were able to identify several risk factors for each of the non-fatal self-injurious events (Table 4, Appendix A). For example, most suicide events involved overdose of medication (58%) and cutting (27%), and over half of patients (57%) involved in a current suicide event had a history of prior attempts. One-third (35%) of soldiers attempting suicide had been stationed in Europe for less than one year, and most attempted suicide in their garrison location (88%). The majority of patients cited relationship and work problems occurring within 3 months of the suicide event.

An important methodological issue became clear when analyzing the pre-surveillance phase data. Since these data were found by reviewing intact patient records, and these records may not always have had the information necessary to complete the form, there was a high percentage of cases in which data on several variables were not available. Thus, for some variables, the descriptive data for pre-surveillance may reflect a smaller proportion of all cases. An attempt to address the high level of *Unknown* on several categories of risk/context factors was reflected in revisions of the data collection forms (to be discussed in evaluation section).

Surveillance phase data collection

Methods

In June 2001, a directive was sent to USAREUR clinics from the USAREUR Command Surgeon instructing them to notify the European Regional Medical Command (ERMC) Social Work Consultant concerning any suicide-related incident. An incident was defined as a non-fatal, self-injurious event ranging in severity, method, and degree of intent to commit suicide. In a two-part reporting process described above, notification that a suicide event had occurred would be e-mailed or phoned in within

24 hours to the ERMC, Social Work Consultant. Second, clinical providers were to complete a suicide surveillance form and send it to the USAMRU-E within 72-hours of the event. Cross-checking between the Social Work Consultant and the USAMRU-E occurred regularly to ensure that both organizations were informed of all reported events occurring in USAREUR. Telephone follow-up to clinical providers completing the surveillance forms was required given the high frequency of missing data entries. Continual monitoring, sharing, and updating of the suicide event data base resulted in monthly summaries that were presented at the Suicide Prevention Task Force meetings and included in the quarterly updates to the Commanding General, USAREUR.

Results: Suicide Event Frequency, Demographics, and Risk Factors

During the 13 months of surveillance, a total of 161 non-fatal events was reported. The monthly average of 12.4 (Figure 6, Appendix B) is greater than the pre-surveillance average of 8.8 (Figure 2, Appendix B). This is most likely reflective of the variations in sources of information. For the pre-surveillance phase, data came from inpatient psychiatric records at Landstuhl Regional Medical Center, while surveillance data came additionally from clinical provider reports from outpatient psychiatry at Landstuhl and outlying clinics, thus widening the potential population base. We were not able to obtain troop strength data, so were unable to calculate accurate rates. Thus, only frequency data are reported here.

Demographics of the surveillance sample and many of the risk factors indicate no major shifts from the pre-surveillance period (Tables 5 & 6, Appendix A). For example, data for Method, Intent, and Prior History results are comparable to the pre-surveillance data. It appears that changes from pre-surveillance to surveillance in the results for variables such as Resides With and Time in Country may be a reflection in the decrease in missing data. The biggest shift in Context/Risk data is that the percentage of *Unknown* data has dropped significantly giving us more accurate data. However, given

the fairly large amount of unknown data at baseline, it also makes it difficult to compare pre-surveillance and surveillance data. In addition, data concerning Life Problems and Clinical Diagnoses is more complete, showing that relationship and work problems were cited for over half of the sample as occurring within 3 months of the suicide event, and that Alcohol, Adjustment and Personality Disorders were the predominant clinical diagnoses.

Looking at the risk factors, there are many similarities to previous studies conducted with military and civilian populations. For example similar to the surveillance phase rank, gender, ethnicity, and overdose method were found in several military population suicide attempt samples (Holmes et al., 1998; Koshes & Rothberg, 1992; Staal & Hughes, 2001 & 2002; Wasileski & Kelly, 1982). Surveillance phase demographics and risk factors comparable to the civilian population include age (Maris, Berman, Silverman, & Nisbet, 2000), ethnicity (Iribarren et al., 2000; Maris, Berman, & Silverman, 2000), and clinical diagnoses of alcohol abuse (Fergusson et al., 2000; Plutchik, 1995; Rossow et al., 1999; Welch, 2001); borderline personality disorder (Maris, Berman, & Silverman; Plutchik, 1995), adjustment disorder (Goldston et al., 1998), and affect disorders (Goldston, Daniel, & Reboussin, 1996; Plutchik, 1995). Additional commonalities include a previous history of suicide attempts that point to the person's coping methods and susceptibility to more events, and the presence of relationship and work problems (Iribarren et al.; Plutchik, 1995; Rossow et al., 1999).

This section reviewed the data collection phases of the Suicide Event Surveillance program. In the pre-surveillance phase, data were collected by reviewing the medical records of soldiers identified in the suicide event sample. Using the initial form, data on demographics, risk factors and the context in which the event occurred were described. Surveillance data were collected from USAREUR hospitals and clinical providers. A review of the data indicates two key findings. First, with the exception of the missing data issue, there were few changes in the results for demographics, risk factors, and context

from pre-surveillance to surveillance, indicating that the two methods for collecting data were comparable and the monthly number of suicide events over the three-year period of surveillance is relatively stable. Second, results indicate that data on suicide events collected in USAREUR are similar to results from previous studies conducted in both civilian and military populations.

Section Three: The Suicide Surveillance Program Development and Evaluation

Introduction

In this section, procedures, results and recommendations of the USAREUR Suicide Event Surveillance System will be presented in the form of a program evaluation. The structure and organization of the evaluation is based on CDC guidelines for evaluating surveillance systems (Appendix C: CDC, 1988 and 2001). To effectively evaluate the USAREUR Suicide Event Surveillance System, we first describe the importance of the health event, to include accurate measures of the total number of cases, incidence, and prevalence as well as a discussion of intervention that potentially prevent the health problem. This element was addressed in the prior sections of this report where suicide prevention programs were reviewed (Section One) and baseline data were presented (Section Two).

Next, an evaluation requires a thorough description of the system, to include objectives of the system, a statement of the case definition of nonfatal suicide event; and a description of the components and operation of the system. This includes defining the population under surveillance, the time period for data collection, the information collected and who provides it, how the data are transferred, stored, analyzed, and how reports are distributed. This evaluation also addresses issues of system simplicity, flexibility, acceptability, sensitivity, representativeness and timeliness. And finally, a description of the resources used to operate the system and the degree to which the system is meeting its objectives is discussed.

The program evaluation involved three major components. First, the form used to collect suicide event data underwent revision with the intent to improve the quality of data collected. Second, in order to understand the surveillance process from the perspective of the major stakeholders, we conducted in-

depth interviews with a sample of the clinical providers asked to complete the data form. Third, the response rate from the field was assessed.

Form Development and Revision

The first version of the suicide surveillance form was developed in May 2001, based on a modified version of the USAF Suicide Event Surveillance System (SESS) investigation worksheet, AF Form 4273 (USAF, 2001). This version was fielded to USAREUR clinic providers in June 2001. Again, the form was revised for use with the archival data collection at the Bensheim storage facility of 1999 suicide events. Review of the archival data collection with the revised form led to its utilization prospectively in August 2001. The revised form, instructions for completing the form, and a description of the changes made and their rationale, were sent to the ERMC Social Work Consultant for approval and dissemination to USAREUR clinics. A detailed summary of the first surveillance form and the revised form follows. These forms can be found in Appendix D & E.

The first surveillance form

The form was to be completed by the clinical provider for the following events: completed suicide, nonfatal self-injurious event, or other significant attempt to harm self. Only individuals whose records could be accessed in a military facility were to be included. Due to clinician concerns about confidentiality, the victim's name and social security number were not included. Tracking of surveillance forms to prevent duplicate forms and repeated data entries was achieved by a combination code of victim's birth date and event date.

Instructions concerning notification about events remained consistent across the different versions of the surveillance form. The ERMC Social Work Consultant was to be notified within 24 hours of discovery of any three events described above. Notification of events occurring after duty hours was to occur on the next duty day. Within 72 hours of event discovery, the form was to be faxed

or mailed to the USAMRU-E, to include contact information for the clinical provider completing the form.

Categories of requested information included the following: type of event and event date, demographic and military information, event-related information, prior use of military helping services, risk factors of victim, disposition at two weeks after the event, name and phone number of individual who completed the investigation form, and a section requesting any additional information that was not included on the form but was believed pertinent to the case.

Revisions of the Suicide Surveillance Form

The suicide surveillance form has undergone two major revisions. The first revision resulted from the results of the pre-surveillance data collection that was based on review of inpatient medical records. This in-depth review suggested additional information that could be useful in identifying risk factors and triggering events for suicide behaviors. The second revision occurred following the first in-progress report on the suicide project, and subsequent to the initial six months of data collection from the clinical providers required to complete the form.

The first revision, based on findings from the pre-surveillance data analysis, resulted in the addition of several sections to the form. Items concerning military-related risk factors were added, to include the duty environment where the event occurred (garrison, training, or deployed), the soldier's length of time in unit and service, and whether the event occurred 60 days pre- or post-deployment. In addition, more detailed information on risk factors was included, such as specifying the problem areas and prior history in the use of military helping services, and any previous inpatient psychiatric care. Self-mutilating behavior was added as a separate category of non-fatal self-injurious event and specifying any prior history of suicide attempts or self-mutilating behavior. The diagnostic categories were expanded to include Mood Disorders and Other Disorders (i.e., adjustment, attention-deficit and

disruptive behavior, eating, sexual, and gender identity, somatoform, or a disorder not listed). The soldier's initial disposition was added to indicate treatment status at the time the surveillance form was completed.

The second revision occurred following the first six months of pre-surveillance baseline data collection. At this time, the seven-page surveillance form was reviewed to select the most relevant data elements. Selection of items was guided by the low response rates for certain questions (see Table 3 and Table 4 for a summary of unknown categories in Appendix A) and the comments from USAREUR clinical providers responsible for completing the form. Preliminary selection of items resulted in a draft form that was reviewed and finalized in consultation with the Psychiatry Consultant to the Office of the Surgeon General (OTSG) and the Chief of the Department of Psychiatry and Behavioral Sciences at the Walter Reed Army Institute of Research. A revised, shortened suicide form, the AMEDD Suicide Event Report (ASER) was the result of this process. This form would be evaluated by clinical providers in the interview phase of the evaluation. While the clinical providers had not yet used the final ASER, they were asked to comment on it and some of its key sections.

Interviews with Clinical Providers

In June 2002, as the first phase of the suicide surveillance program was ending with the plan of introducing a shortened suicide surveillance form Army-wide, the interview portion of the program evaluation was conducted with some of the USAREUR clinical providers who had participated in the program. The primary goal of the interview phase of the evaluation was to review and evaluate the surveillance forms and the surveillance process via interviews with users of the form. The clinical providers were asked to provide feedback on the suicide program and their perceptions of and experiences with the Suicide Investigation Form, as well as their views on the surveillance process. Their comments were organized into topic areas that included the strengths and weaknesses of the

form's content and suggestions for improvement and the benefits and drawbacks of participation in the program from the perspective of patient care and clinic resources. The providers were also asked to review a draft of the "New Form", the new, shortened ASER form (see Appendix F).

Methodology

A total of 32 clinical providers participated in the Suicide Surveillance Program. We identified participants from the data on the Suicide Investigation Form. If any care provider completed 2 or more forms, they were included in this group.

Sample selection and procedure.

Of the 32 providers identified, a total of 10 providers were selected to participate in the interview component of the program evaluation. A purposive sample was selected, in that we attempted to interview providers that varied on several factors: amount of experience with the form, type of provider and care setting. First, we wanted to include providers who had a varied range of experience with form completion. On average, participants completed 8 forms, with a range of 2 to 32. In addition, we wanted to make sure that different types of providers from different types of care settings were included. Our sample was composed of psychiatrists, psychologists, and psychiatric nurses in major European Regional Medical Command (ERMC) hospital sites as well as in outlying clinics throughout ERMC. Participants were contacted by telephone and asked if they would participate in a 30-minute interview concerning the Suicide Surveillance Program. Eight of the ten interviews were conducted at the clinical providers' work place, and two were conducted by telephone. Phone interviews were conducted with providers who were located outside of a reasonable travel distance. An interview time was determined, in which our interviewer traveled to the workplace of each participant or contacted the participant by phone. The interview questions are found in Appendix G. Interviews were tape recorded and transcribed.

Analysis of interview data.

Using NVivo, a computer software package for analysis of qualitative data, transcripts of interviews were first coded for general content categories. Then, a finer level of analysis was completed in which we sought to identify major issues and perspectives about the Suicide Surveillance Program. Results were then organized into general topic areas and are presented in the next section. We include actual quotes from participants in order to provide evidence for the summarized views concerning the program.

Results

Results of the interview data are organized in the following manner. First, we summarize the views of the ten clinical providers about the forms used for the study – their views of the strengths and weakness of the original form, as well as the degree to which they felt the 'new' form has improved. Second, we discuss the process of surveillance, including the amount of information provided to the clinical provider, the benefits of data collection for patient care, and the degree to which the provider finds value in the surveillance process. Third, issues of implementation of the surveillance system are discussed, including barriers and/or resistance to using the system, and ways in which compliance with the surveillance system could be enhanced. General issues and perceptions, along with a small number of supporting direct quotes from respondents are presented in this section. More complete interview responses are included in Appendix H.

The form.

In the first part of the interviews, clinical providers were asked to provide feedback to us on the forms used in the study.

Time and resource issues. An overwhelming amount of comment from providers involved the length of time required for form completion;

> "Well, it comes down to what results you really expect to get. In the present form it will continue to be incomplete and catch as catch can, so I would have my doubts about that unless something was done to make it less burdensome. One of which would be to remove the 24-hour deadline for reporting. During the emergency period on call is when you have the least administrative time available to complete the form. If you make it a week later you might get an even better response." (Interview 4)

or, that other clinic considerations would be higher priority, thus leaving suicide reporting as something to put off.

> "Even if they're screaming at us loud and strong, I think the reality is going to be the same. There are going to be months at a time that we're not going to get to it [the form]. Then maybe a day or two or week here we can get to it. It's going to be the same issues." (Interview 8)

When asked about how the 'new' form compares to the older form that clinical providers had experience with, there was a sense that the new one would take longer to complete, which could be viewed extra work, or detract from patient care.

> "Over 100% longer! This could take a half-hour, easily, or longer. It takes 10 minutes to do the old one. This is NOT going to work! (Reading) 'Risk management analysis' whew! Pardon me if my affect is showing! I don't need all this extra work! That's ridiculous! That is NOT going to fly!" (Interview 5)

> "There's a lot of paperwork and interviewing that already has to occur, and by the time she gets to see the patient, they may have been waiting several hours and are usually very tired. "Going through another 7-page thing, it's hard. It's hard on anybody. Even when you are seeing a patient on the ward, you know you have to do the intake, it's easier to do it on the ward, but again on the ward it gets pretty busy. You can have five new admissions to see. On the outpatient we have about 30 or 40 minutes to do everything and to get the patient on the ward because you've been on call." (Interview 3)

> "Frankly, when I had to choose between filling out the form and taking care of the next patient, I would take care of the next patient and the forms would sit and they would accumulate, and I might get to them and I might not. Frankly when I was exhausted and sleep deprived, I really didn't care to go back and to fill out the accumulated forms. So, since we're going in for the honest version, looking over the months, I am sure there are several times that I never did get back to the form, either forgot about it or was too embarrassed after several weeks and I just thought that I should just forget it so it didn't get done. It got done sometimes." (Interview 4)

Apparently, there was some concern with the initial determination of whether or not to even complete a form on a patient.

> "I honestly did not fill out a form on everyone who came in here who scratched their wrists. Maybe I should have because it's dangerous behavior, and that leads to further dangerous behavior, leads to suicide. Anyway, my fault, but do they want that? Do they want every self-mutilation? Because it's not a suicide attempt! Patient comes in and tells me "I didn't want to kill myself, I just wanted to relieve anxiety." (Interview 5)

> "There again, one of the things that makes it more onerous is that quite a few patients make very minimal self-injurious acts, like fingernail scratches on the wrist where the same patient may do these things several times a week for months on end. It'd be a lot of forms if we strictly adhere to the criteria of any self-injurious acts. This becomes a running joke that we have another 7-page form to do. That doesn't mean that we don't do it well, sometimes we don't but we get to resent all the paper that's being sacrificed for the minimal and repetitive acts." (Interview 4)

Interpretation of instructions. Another set of problems discussed about the forms involved difficulties in interpreting form instructions:

> "What is ethnic group none and other? Also, where is one for Caucasian/White? MACOM could be shorter, don't see the majority of those listed." Interview 6

> "Who is supposed to fill it out, specifically? THE PROVIDER. Which provider, specifically? WHOEVER IS SEEING THE SUICIDAL PATIENT? To include the emergency room or family practice? That does not get done!" Interview 2

> "The business of "communicated intent to" that sounds like a simple question but it actually takes a fair amount of questioning of somebody to come up with idea that "did you ever tell anybody." Interview 8

> "It's just that when you're filling out the form and you got to some of those blocks, I didn't really know what to put there. Am I going to go back to the patient and asked if they saw EFMP within the past year? If I'm not that busy, I probably could do that, but to be honest with you, I never did that. It was all a best guess situation." Interview 5

Related to clarity of instructions, some providers had issues with determining the severity of attempts and need to complete a form.

> "We're an inpatient ward. The vast majority that come in here are personality disorders, vast majority. They all have some self-mutilation history. Is it a serious suicide attempt if someone puts a loaded gun to their head? Are we going to fill out forms for that?" Interview 5

> "I wouldn't mind doing this for the completions . . . it's too much for attempts!" Interview 1

Value of Information Suicide Investigation Form Provides. When asked if there were any benefits of collecting information on attempted suicides, one provider stated

> "No. What can you possibly learn from this. I don't see any value in that. For any number of reasons, suppose that you find that the vast majority of suicide attempters are white or black, so. What does that tell you? Nothing. Suppose you find out that 80% had financial trouble. Does that tell you anything? No, that doesn't tell you anything clinical about what to do and what not to do." "Suppose you find that there a cluster of 3 of the 5 suicide attempts in the Wiesbaden area. Does that tell you anything that you can do anything about? No, it doesn't. I don't know what the value is." Interview 10

Need for Additional Patient Information. Also, some clinical providers did not approve of the need to seek out additional patient information from sources nor readily accessible, such as other medical agencies or patient history.

> "I'm not really sure what to do with this, because does this mean that I need to go back and research every appointment that this person has had in the last year to see if he or family members have been involved in this? A lot of times this is kind of my best guess from taking the history "Well he didn't talk about any financial problems, so I guess he didn't have any financial counseling" kind of thing. Some of it is no-brainers, but a lot of it is again my best guess." Interview 5

> "Helping Services - provider does not have time and isn't going to contact the different agencies. Risk Factors - provider is not going to know most of these and again, does not have time and isn't going to seek out the information" Interview 6

> "Even something like that, but when you talk about did it happen exactly in the last three months or not, that's again one of those measurement things where you're probably not going to get a real good answer on that." Interview 8

Narrative section of New Form. Many of the providers commented on the narrative section added to the new form. On the positive side, the narrative allows for a more complete description of the event.

> "This is new. In a way it's more complete. It kind of gives you an overall picture, because it's [risk factors] not just one thing. Many times I write on this form anyway to clarify the answers she has given in the bubbles. Sure. It doesn't take that much longer, but it still takes time." Interview 3

> "The narrative summary allows you to get into more reality." Interview 4.

> "I think the narrative part adds a qualitative aspect. Sure!" Interview 2

> "I think that the one big advantage that this form [revised form] has over that one [7 page form] is the narrative. Where you have a chance to say things and come up with some sensible narrative that that form doesn't allow. Most of these will be filled out on the psych autopsy but

> you have the opportunity to write why the solder chose to injure themselves, it doesn't have to be kill themselves. To me that is one of the major pluses." Interview 10

However, there were also negative comments about the narrative section which focused on the notion that it was time consuming and didn't any additional information already provided on the form.

> "It's again something, we already produce those records and why aren't those records adequate? The issue is, the information is probably already there. The information is recorded clinically. This is largely redundant or it involves getting in to areas that we don't have information about. We'd have to spend additional time interviewing patients." Interview 8

> "That's ridiculous! This is not going to get... I'd rather do this form! (Indicating the longer, "old" form). This is going to be frustrating! I am NOT going to write a narrative well, I will if I'm told to but it's unlikely that I'll have 100% compliance with filling out this form on every patient that comes in with a laceration that winds up being hospitalized." Interview 5

> "That will dramatically increase our workload. Dramatically! I do not have the time to write a narrative summary on every patient that gets admitted that has a self-mutilation or a suicide attempt. It isn't happening!" Interview 5

> "Everything that I write out here (in the narrative section) is just going to be a consolidation of all the stuff that I've just clicked off on. I think this is redundant, overkill, whatever you want to call it." Interview 1

> "Narrative Summary! That will take even longer. If you really intend for this form to be filled out in a paper format, you'll have illegible handwriting in there, so you'd better put it on line. My own handwriting is awful and some doctors are worse. You don't want to get yourself into that space. I hope you know what you're getting yourself into. Somebody's going to have to interpret all those mangled sentences, even if you could read them. That could be a great deal of work." Interview 4

One respondent summarized the group's overall reaction to the narrative:

> "Anything that does require a narrative is going to be more work, and in that sense, something that requires a thoughtful answer. I think there will be varying response from clinicians. I think some will give some very helpful information and others will not do so." Interview 9

Overall Value of the Suicide Investigation Form. Clinical providers were also asked their views on the form as a whole. Once again, it appears that the logistics and mechanics of form completion, along with the accompanying time and resource issues, were a concern for many. Nevertheless, several respondents addressed the value of the form.

> "I think the part that I had the most trouble with was the history of the use of helping services. There are quite a few bits in there that wouldn't necessarily come up in the course of an interview and unless I thought specifically to tailor the interview to fit the form, it wouldn't happen. More often than not when it came to the exceptional member family program, I simply hadn't thought to ask, and so it usually would be 'unknown' or once in a while it may coincidentally have come up. Financial counseling? I've never been in the habit of asking about that. And so on... A few like mental health or the chaplain, those would regularly come up, but often a lot of ambiguity or blanks on the form came from that." Interview 4

> "It is fairly straightforward and fairly simple. I think in that sense, for the amount of information that it attempts to gather it's a good form." Interview 9

> "The use of military helping services, I like that. It kind of gives you an overall picture, because it's not just one thing." Interview 3

> "Usually they tell me if they had financial counseling, or financial problems. You usually have an idea if they are going out a lot, wearing very trendy clothes - where are they getting their money? How much money are you spending drinking? I'm sure they are going to have some financial problems." Interview 7

> "It's an easy form to work through. I like the check boxes -- the form is well written and easy to follow". Interview 7

One overall concern involves the perception that some of the information required on the form is redundant, or a waste of time and effort. Some required information is already in the patient's file, or require a great deal of extra effort in tracking it down.

> "This is largely redundant or it involves getting in to areas that we don't have information about. Much of the data is either already captured and for example, in terms of gender, the date of birth, all these things exists already on the thing or the other. Looking at the redundancy issue is that these are factors that we routinely record on the history and physical and where if there was someone who came and looked at the history and physical, looked at the charts, they would be able to pick that up and score it pretty easily, but for us to get into another form. I think the history that everybody sees is we haven't done it consistently. " Interview 8

> "This is harder to find out unless I talk to a family member." Interview 7

> "I already have this information. I already GET this information. It's in the chart or it's in my head." Interview 1

The process of surveillance.

Given that success of this surveillance system depends in large part on the willingness of health care providers to complete forms thoroughly, it is important to understand the attitudes of the clinical providers about the overall process. In this section, we will summarize the perceptions held about the implementation of a suicide data collection system.

Is Surveillance Useful? Many of those interviewed addressed the degree to which they found the information that the system would provide to be useful.

> "There are some sections that I like about this. The military information, I think it's very good. 'Where the incident took place,' for instance, was it in the barracks, was it was in the field. If you could get the unit, some units have more cases than others, depending on the MOS So it's interesting if you have any peaks in certain units that show up more than others. The event information is very good, the communication, if the intent was communicated to anybody. If alcohol or drugs were used during the event. The use of military helping services, I like that. It kind of gives you an overall picture, because it's not just one thing." Interview 3

> "Clearly somebody wants to study rates or qualities of self-injurious acts and I would hope it's with the intent that somehow we could better intervene or prevent such acts." Interview 4

> "I'm aware that the army's study of completed suicides has been very sketchy because many of the psych autopsies never make it up to the big database and hence the information is incomplete. It probably remains to be seen if this new method is going to garner better data." Interview 9

In addition to their overall views on the surveillance system, several respondents described their views regarding benefits to patient care.

> "I don't think it's [patient care] changed. We have our own check sheet for the outpatient, and from that you derive your diagnosis and you kind of go from there. It hasn't shaped the way we treat patients. You're touching on a lot of the characteristics the demographics, the pre-treatment, the post-treatment, if they've sent the chaplain, what resources have they touched before they come to us. I think it's been good." Interview 2

Negative Views on Surveillance. Several providers displayed a somewhat pessimistic view about the surveillance system – that collecting this data would not improve patient care and it would mislead people into thinking something was being done to prevent suicide and attempts.

"In truth I wouldn't do it. It has some aspects of a noble effort, trying to learn the truth about things, but what are you going to learn? You'll learn what we've always known -- that people get depressed about things and sometimes they feel like offing themselves. As far as really productive changes that will come from this, I'm dubious but hopeful. My experience to date has been that a great deal of fuss and bother has been put into so called suicide prevention with relatively little impact. People continue to get depressed because they are human, and people continue to consider and act out on self-injurious impulses. All the education in the world and all the administrative and institutional programs saying 'don't kill yourself' it's not going to stop them!" Interview 4

"I don't grill the patient about these specific criteria because there is so much in modern medicine these days that we have to ask that the provider feels is superfluous to the issue at hand, that I'm not going to. That's the worst thing about the form is that it takes a lot of my time and my providers time, and I don't think it can help." Interview 1.

"We know why people kill themselves. The biggest problem with this is that it gives a misperception to command that we're doing something. It gives them that feel-good sense. I'm not saying that there is necessarily anything that can be done in any hierarchical level, but it gives the wrong impression to leadership if they think we're doing right by the soldiers, by the military, and the army, the USAREUR, by doing this. It gives the wrong impression that we're taking care of the USAREUR community doing this report." Interview 1

"Everyone is apathetic about healthcare needs until somebody dies. The system is broke for healthcare and it's going to get worse." Interview 6

"I don't believe this form is it. I think it will be a lot of man-hours and money expended for very little or any return. It may satisfy a political issue because somebody wants it. In terms of science, I don't think so." Interview 10

"In fact it probably detracts more from patient care than adding anything positive to it." HOW SO? "It's more forms the doctors have to fill out instead they could be doing something else than filling out this form. In no way does this contribute to patient care. They are wanting to know if drugs were used during the event and was alcohol used during the event and if in fact were substance abuse services used a month or 12 months before the event. That really doesn't address the real issue about personality disorder and so forth and that is the main issue behind suicide attempts. I don't know that this form is going to help a lot with identifying the real issues." Interview 10

Benefits of Surveillance. On the other hand, several find this system to be of value.

"What was helpful to me mostly was the briefing topic when you [USAMRU-E] came and did the study where you figured out how many suicide attempts we had in the last year. I think that it is a reasonable thing for us to know about and I do use that when I talk to commanders." Interview 8

"It kind of gives you an overall picture, because it's [risk factors] not just one thing. This is what it [the data collection form] does, you sit down and focus." Interview 3

"The positives are that I think it's a fairly decent tool, there's a lot of good data. It made me think a little bit of all the other things that are out there. It's an easy form to fill out" Interview 5

"I think you can probably derive a lot of correlations from this. I think the risk factors are important to annotate." Interview 2

"You have a complete picture of the patient when you do the discharge summary; it's a good focus on the patient. So I really like the idea, and that at least for now we can see what units are doing poorly. Is that because of the MOS, because of the GT score? So you have people with less coping skills for certain MOS, and that's why traditionally you would have more cases. Or is it traditionally that you had poor leadership? Or is it a very stressful, high-risk unit anyway? Who knows?" Interview 3

"It will give us a firmer database to try to address that particular area [collecting serious suicide attempt info] that I think has not been particularly well addressed in the suicide literature" Interview 9

Implementation of the surveillance system.

In this section, we will summarize the comments and suggestions made by the clinical providers concerning implementation of the suicide surveillance system. Many of the comments to follow indicate willingness on the part of many of our respondents to support the program and see that the efforts expended will be worthwhile. However, several providers accentuated the problems with the form and the barriers to successful implementation. While many of these negative comments are aimed at the time and resource issues involved in completion of the form, and have been discussed previously, it may be important to reiterate these perceived barriers.

Barriers to Surveillance System Implementation. Among the perceived barriers to successful implementation, the time and personnel required to complete the form was the primary challenge.

"It's just one more thing. When you interview a patient, it's a lot of paperwork and you can imagine where a new patient coming in has a lot of paperwork, so it's a lot of time. In the emergency room, frankly I never did [the form] because it takes me too much time already with the patients, you know, they want to get out of there. So something like this that would take 20 or 30 minutes, because you have to read or don't have all the information while on in-patient you

do. You have their chart, that's very complete. When you're on call, you have your patients so you need time to do your notes." Interview 3

"Patient Care comes first and all paperwork comes after that. We can promise to do it we can be threatened and be told to do it, but the reality is that we're going to end up not getting it done, because we just have too much else to do. I had one of these forms that laid on my desk for about three months and it was exactly half done where I had started and something else had come up and I just never got to it." Interview 8

"Frankly when I was exhausted and sleep deprived, I really didn't care to go back and to fill out the accumulated forms. So, since we're going in for the honest version, looking over the months, I am sure there are several times that I never did get back to the form, either forgot about it or was too embarrassed after several weeks and I just thought that I should just forget it so it didn't get done. It got done sometimes. When I had to choose between filling out the form and taking care of the next patient, I would take care of the next patient and the forms would sit and they would accumulate, and I might get to them and I might not. I hope this means that I won't be tracked down and prosecuted for failure to fill out the forms; it wasn't from ill intent, it was just exhaustion." Interview 4

"I'm a zombie doing admin work requirements, and the form is one of many. Providers are swamped with duties to fill out admin forms; too much paperwork is an administrative burden. The system is broke for healthcare and it's going to get worse." Interview 6

"I am painfully aware in my own experience that there have been patients that I have seen and may have thought about filling out the form and haven't done it. I think all of us feel that we spend far more time filling out papers than we should because it means less time that we have to be with patients. I think most of us feel that face-to-face interaction with patients is what we do best. It's what we're good at." Interview 9

"I think you just know that if you see someone a couple of days later, you just know the ER hasn't done it, so it's probably not the first [treatment]. I guess when you think of suicide, you think of an emergency; something you really need to get to, so I think it's almost an afterthought." Interview 2

"It's filled out by one person in the clinic, and if I'm not aware that something has happened, then it doesn't get filled out. It takes about 30 minutes to fill out each form including phone calls to units, chaplains and records clerks." Interview 7

Limitations in Resources. Reductions in resources in the military health care system overall, and specifically in mental health care, were cited frequently as additional barriers to implementation.

"The numbers here are fairly overwhelming. To give you an idea... it's a 30% increase over what we did in 1994, but with 50% less staff. We have something like in the vicinity of nine techs, in 1994 we had eighteen." Interview 8

> "The number of providers has been decreased this year, but patient count is higher... If you didn't have time during your admission because you had two or three admissions at the same time." Interview 3

> "Likewise with some of the life events, we generally get a pretty good handle on that but not necessarily in every emergency interview, as far as past criminal activity and legal problems. Obviously relevant history tends to be incomplete. It's relevant information but we wish we had the manpower to do it thoroughly and efficiently. One of the solutions would be to hire a lot more doctors and pay them a lot more money and then we'll have more time to fill out the forms! It will only cost a few billion." Interview 4

Suggestions for Effective Implementation. Despite the many perceived barriers to implementation of the surveillance system, clinical providers were also able to provide thoughtful and practical suggestions for a smoother, more successful implementation. Some of the suggestions targeted the mechanics of getting the form completed and returned to the appropriate person, while other comments concerned the preference for paper or electronic format of the system. Not surprisingly, no one thought the form was too brief!

> "It's something that they could do on-line. Even if it was just like fewer pages. Maybe the question would be 'what are you trying to track down with regards to suicides?' 'What is important for you, or whoever is doing the study, to know?' You may not know everything, but what are you going to do with all the information?" Interview 3

> "I have it on my computer, I just print it out. I would probably rather have it in this form (indicating paper) than to have it on the computer to tell you the truth. It's tedious to click around. I'm not one of those people who is totally automated. I still like some paper forms. It is time consuming, and again it just needs to be in the mindset, but I think if the form were streamlined and we were given additional guidance as to why we're doing this form, here's what we're doing so far." Interview 5

> "The current form is not set up for easy electronic completion; it's too cumbersome" Interview 6

> "It's just the length. It's not difficult to fill out, but just by chasing it in the fax machine and it's been broken -- it's just those things. I think it's just administrative, I think the information and the questions that are asked are fine. I just think it could be done more easily on a computer you can just 'X' it and send it in. Faxing -- just we don't have a really great fax. Put it on the computer so we can e-mail it to you, and that's really it." Interview 2

> "We're talking about patients that sometimes we see at 0-dark-hundred in the emergency room, or on a very busy clinic day when we know that every extra minute we take with this patient

means more to those out in the waiting room will have to wait. So, obviously the simpler the form is, the more likely you are to get accurate information." Interview 9

Communication and Feedback. Another theme in successful implementation involved communication with the person or office handing the database. First, persons or clinics expected to complete the forms should receive some form of communication about the surveillance system --why it is being done, what it is accomplishing. In addition, they would benefit from timely feedback on adequate completion, and 'gentle' reminders to complete and return the form.

"Maybe just a gentle reminder every couple of months that it's out there any we have this, we hope that you're using it. I'm sure that there might be people that are skating through it. Those kinds of things, just gentle reminders." Interview 2.

"All anyone ever told me was "do this!" And I've never been told why and where the data is going." Interview 5

"This is great, to see you guys here and so interested in the form, asking for my feedback and changing the form, that will make me think more, have it in my mind to do it." Interview 5

"I guess it would be nice if we could see what it was being used for and if we knew that this was changing anything as opposed to just collecting a bunch of data. Are we using this data? Well, if they just sent us an e-mail that said, "Hey, you know all that paperwork you've been doing? We published a paper, and here are the results and here's how we're going to apply them in USAREUR, or army-wide. If you want to see the article, it's in this journal, or whatever." Interview 5

"It wasn't entirely clear how long the project would go on, in fact I'm not even sure, is it still running?" Interview 4

"Is anybody even looking at this stuff? Does anybody even care if I forgot about one patient?" Interview 7

"If you want the people to do this and support them and take it seriously you're going to have to show people this is what we've found. That's the basic tenets of science. You don't do something and hide it under a barrel and frankly that's what's happened here. If you expect people to do this and fill it out, then you're going to have to share with them what's been found so they feel that they're doing something productive." Interview 10

It seems that if the clinical providers were to get feedback and information on the types and amounts of clinically relevant information provided by this system, it would be of benefit to them, and may be important in enhancing their motivation to participate fully in the process.

> "So I really like the idea, and that at least for now we can see what units are doing poorly." Interview 3

> "As a physician, we take a clinical history and this is not the typical form that we use. It's not a form that we're used to doing. It's a matter of getting into the mindset of "I know I'm going to see a patient who had a suicide attempt this morning. I need to remember to pull out that form and make sure I answer some of those questions? This is something new to me; I didn't use it in my prior duty location". Interview 5

> "When you have a form that covers so many areas, obviously there are going to be some that are not readily available. We'd have to be interviewing patients, thinking specifically of the form, rather than trying to make a clinical decision. I don't think that's a very wise thing, and really its not very practical. I need to be honest, for example when they talk about the use of military helping services, some of these items we have the information and some of these we simply do not have the information. Typically if we're interviewing someone in crisis, which is after a suicide gesture - we rarely go into whether or not they've been in touch with child and youth development. I just need to be realistic about that, and so in those cases we will mark 'unknown'." Interview 9

Summary and discussion

In this section, we summarize the general findings of the clinical provider interviews. Regarding the form, some of the common concerns included:

- the length of time required for form completion
- form completion may detract from patient care
- how to make the initial determination of whether or not to even complete a form on a patient (severity of attempts)
- difficulties in interpreting form instructions
- the need to seek out additional patient information from sources nor readily accessible
- some of the information required on the form is redundant

Clinical providers also provided some insights into their perceptions of the value of a suicide data collection system. Comments on this topic included:

- the degree to which they found the information from the system would be useful
- the degree to which the system would benefit or detract from patient care
- the data would not improve patient care and it would mislead people into thinking something was being done to prevent suicide and attempts
- the value in providing an overall picture about suicide and risk factors
- the narrative allows for a more complete description of the event

Barriers to implementation of the suicide surveillance system included:

- the time and personnel required to complete the form were the primary challenges
- reductions in resources in the military health care system overall, and specifically in mental health care

Suggestions for a successful implementation included:

- provide adequate resources
- electronic or more streamlined mechanism for getting the form completed and returned to the appropriate person
- communication with the person or office handing the database --why it is being done, what it is accomplishing, getting timely feedback on adequate completion, and 'gentle' reminders to complete and return the form
- providing information on the types and amounts of clinically relevant information provided by this system

Response Rate Evaluation

The goal of this part of the evaluation was to determine the level of response to the surveillance system since its implementation. For a measure of response rate, we compared the number of suicide events determined via an independent records review to the number of forms returned by clinical providers in the surveillance system.

The findings indicated a solid 82% response rate during the first 6 months of surveillance, suggesting that the system was working well. The second 6-month phase, however, showed a significant drop in response rate to 35%. While the number of total events over the 2 six-month time

periods showed no significant change, the number of forms received showed a significant decrease over the same time period (see Figure 7 in Appendix B). One on the most plausible explanations to this drop in response rate involved the US Army's response to events of September 11, 2001, and participation in activities around Operation Enduring Freedom (OEF) beginning in October 2001. This included drops in hospital and clinic personnel due to deployments and increased participation in Force Protection activity, along with increased hospital admissions as a result of casualties associated with OEF. Within a month of September 11, USAMRU-E received a request from one of the major medical centers in USAREUR for assistance with Suicide Event Surveillance Program. Our staff responded by returning to the patient record review process to 'fill in the blanks' of those incomplete forms that were returned to us.

In March of 2002, the Psychiatry Consultant to the Army Surgeon General initiated the fielding of the ASER Army-wide. This was postponed in USAREUR until July 2002 so that a full year of surveillance data could be collected with the same form used over the course of the program. In July 2002, USAMRU-E's participation in the Suicide Surveillance Program ended.

Summary and Recommendations from the Evaluation of the Suicide Surveillance System

To summarize the findings of the evaluation, it would be useful to return to steps in developing a surveillance system discussed earlier: 1) determine, define and describe the health event under surveillance, 2) describe the objectives of the system, 3) describe the actual operation of the system and its components and, discuss the use of the surveillance system, and to recall the system attributes that were also evaluated – simplicity, flexibility, acceptability, sensitivity, representativeness and timeliness. The USAREUR Suicide Event Surveillance System was very successful in addressing the elements of the first step (to determine, define and describe the public health importance of the health event, and its relevance to the Army).

The evaluation revealed several problem areas relevant to describing the system and its procedures. In terms of describing the system, there were some problems with a description of the system as evidenced by provider comments and response rates. Instructions and definitions could have been made clearer as the system was implemented. A general finding from the interview data indicated a lack of acceptability of the system. There was a perception that the time and resources required to collect accurate data exceeded capabilities. Many providers did not see value in the system, and others felt that the usefulness of the system was limited.

A second major problem area involved the system's flexibility. According to the CDC, "a flexible surveillance system can adapt to changing information needs or operating conditions with little additional cost in time, personnel, or allocated funds". This system did not adjust adequately to the overwhelming demands of OEF. While it would be difficult to expect any surveillance program to respond flexibly to such demands, one could say that a successful Army-wide surveillance needs to be more flexible in order to anticipate medical contingencies given the nature of Army operations in recent years.

Third, there were some challenges to the timeliness of the system. During the surveillance phase, particularly when external events (OEF, September 11, etc.) occurred and resources were overwhelmed, forms were incomplete and additional time and resources needed to complete them. Since the need for speed in the surveillance system depends both on the nature of the public health problem under surveillance and the objectives of the system, it is important that those objective match the time requirements of data collection.

Fourth, as evidenced by interview data from clinical providers who deliver the data, and the response rate data during the later part of the surveillance phase, acceptance of the system was low. Providers were unclear as to why they had been asked to complete forms, and felt overwhelmed by time

and resources required to complete the forms. After the events following September 11, resources were further stretched, and compliance dropped significantly.

Several of our recommendations to improve the Suicide Surveillance Program focus on the important system attributes of simplicity, acceptability, timeliness and flexibility. Simplicity could be enhanced by taking into account providers concerns about the length of the form, ease of use, clear definitions and instructions. Acceptability could be enhanced by communicating findings around risk to the personnel collecting the data and to the wider medical community. This information should consider both etiological factors and triggering events of suicide attempts. In addition, acceptability would be enhanced by developing prevention programs based on data. The timeliness of the system could be enhanced by developing an automated data entry tool. Flexibility could be addressed by enhancing simplicity, acceptability and timeliness, such that 'real-world' events such as OEF and September 11, 2001 do not overwhelm the system and the personnel involved. A more streamlined approach, with a shorter form that is automated and electronically submitted would serve well. Linking the shorter form with patient records for retrieval of additional information about risk factors would be advised.

Other suggestions would require a shift of priorities in the objectives of the surveillance. If it were sufficient that accurate data were collected in a manner similar to the pre-surveillance record review procedure, perhaps it would be possible to transfer the responsibility for data collection from clinical providers to other designated staff. This would result in a time lag between event occurrence and entry into the database, yet would allow for complete data and even follow-up information. Use of subject identifiers should be allowed to enable linking data with the Health Care Utilization Database at CHPPM and the Defense Manpower Database Center (DMDC). The objective is to link the suicide data via a common DOD database with the CHPPM and DMDC databases for program analysis and research planning.

In summary, the US Army Europe's Regional Medical Command and Suicide Prevention Task Force recognized a need for accurate, timely data on suicide events in USAREUR. A data collection surveillance system was developed and implemented. Pre-surveillance baseline and surveillance data provided useful information on suicide events and their associated risk and life context factors. Given real world events and the time/resource issues around collecting the data, the challenges of developing and implementing a suicide event surveillance system have been described. The process of developing and evaluating an on-going suicide event surveillance system marks the first attempt to establish such a system in the Army. While suicide event surveillance is often recommended, it is rarely conducted.

The development of the ASER and the program evaluation of its origins and evolution supported Science and Technology Objective W: Enhancing Psychological Resilience to Prevent Psychiatric Casualties, a program of research within the US Army Medical Research and Materiel Command's Research Area and Directorate III. Suicide risk factors within the Army population were identified using retrospective and prospective methods of data collection. This effort has led to the development of a model of military related suicide event risk factors, some of which overlap with the civilian population, but many of which are unique to the military.

The combined efforts of the Suicide Prevention Task Force, European Regional Medical Command and the input from the clinical providers in USAREUR have resulted in a revised form and procedure that has been delivered to the Surgeon General of the Army. The AMEDD ASER was subsequently implemented Army-wide.

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Appendix A – Tables

Table 1: Civilian Suicide Behavior Statistics

Completed Suicide – 2001[1]	Attempted Suicide
• 11th leading cause of death for last three years (1998 - 8th leading cause) • Top three methods: firearm (55%), suffocation (20%), and poisoning (17%) • 3rd leading cause of death for age groups 15-24 and 25-34 • Caucasians have highest rate of all ethnicities[1-4] • Males are 4 times more likely to complete suicide than females and 7 times more likely to use a firearm than females • 2000: white and black youth, ages 20-24, had highest rate using a firearm[2]	• Females in teens and 20s and males in 20s have highest rate[3] • Females attempt 3-4 times more often than males[10] • Caucasians have highest rate of all ethnicities[3,4] • Alcohol[5] and substance abuse commonly associated with attempts [6,7] • First time adolescent attempters more often have adjustment disorder[8] • Repeated adolescent attempters more often have affect and anxiety disorders[9]

[1] CDC, 2003
[2] CDC, 2002b
[3] Maris, Berman, & Silverman, 2000
[4] Iribarren, Signey, Jacobs, & Weisner, 2000
[5] Rossow, Romelsjo, & Leifman, 1999
[6] Fergusson, Woodward, & Horwood, 2000
[7] Welch, 2001
[8] Goldston, Daniel, Reboussin, Reboussin, Kelley, & Frazier, 1998
[9] Goldston, Daniel, & Reboussin 1996
[10] "Suicide – Part II," 1996

Table 2: Timeline of USAREUR Suicide Task Force and Suicide Surveillance Activities

Command Activities	
FY 2000	Suicide Prevention Task Force commissioned by USAREUR CG (GEN Meigs)
May 2001	CG ERMC tasked USAMRU-E with data collection and analysis to support USAREUR Suicide Prevention Task Force
Feb 2002	In-Progress Report briefed to CG ERMC
Project Activities	
Jun 2001- Apr 2002	Pre-surveillance Phase: Data Collection and Analysis of Inpatient Records from May 1999 through May 2001
Jun 2001 – Jun 2002	Surveillance Phase: Data collection from fielded Jun 2001, revised Aug 2001
Project Completion	
July 2002	AMEDD ASER implemented (MEDCOM) USAMRU-E role ends

Appendix A – Tables cont.

Table 3: Pre-Surveillance Data: Demographics (N=221)

Rank	86% E1-E4; 13% E5-E9; 1% Officer
Age	70% <25 years old; 21% 25-30 years old; 9% >30 years old
Gender	72% Male; 28% Female
Ethnicity	61% White; 26% Black; 5% Hispanic; 4% Asian; 1% Native American; 1% Other; 2% Unknown
Marital Status	45% Single; 42% Married; 7% Divorced; 1% Legally Separated; 5% Unknown

Table 4: Pre-surveillance: Risk Factors (N=221)

Method	58% Overdose; 27% Cutting; 6 % Other; 9 % Multiple Methods
Medical Severity	31% Mild; 49% Moderate; 5% Severe; 10% None; 5% Unknown
Victim's Intent	33% Mild; 41% Moderate; 15% Severe; 11% Unknown
Duty Environment	88% Garrison; 9% Deployed; 3% Training
Prior History of Attempts	57% None; 32% prior history (13% attempted in the past year); 11% Unknown
Communicated Intent	20% None; 18% Friend/Coworker; 7% Family; 15% Other; 40% Unknown
Resides with	24% Alone; 20% Spouse or children; 2% Barracks Roommate; 4% Other; 50% Unknown
Location of Event	25% Barracks; 13% Personal Residence; 12% Other; 50% Unknown
Time in Country	35% in country 1 year or less, 52% Unknown
Life Problems	Relationship (68%) and work (52%) were the predominant life problems reported, with the majority occurring within 3 months of the suicide event
Clinical Diagnoses	Mood Disorder (48%), Alcohol Abuse (42%), Adjustment Disorder (38%), and Personality Disorder (33%) were the predominant diagnoses

(Definition of Medical Severity: Mild - superficial, transient, or self-limited event, Moderate - required treatment, but not life threatening, Severe - was likely to be fatal without treatment. Definition of Victim's Intent: Mild - self-injury with primary goal to receive attention or assistance, Moderate - self-injury with primary goal to harm self, Severe - self-injury with primary goal to kill self)

Appendix A – Tables cont.

Table 5: Surveillance Data: Demographics (N=161)

Rank	83% E1-E4, 17% E5-E9
Age	68% <25 years old; 19% 25-30 years old; 13% >30 years old
Gender	70% Male; 30% Female
Ethnicity	63% White; 21% Black; 10% Hispanic; 3% Asian; 3% Other/Unknown
Marital Status	52% Single; 38% Married; 8% Divorced/Separated; 2% Unknown

Table 6: Surveillance: Risk Factors (N=161)

Method	60% Overdose; 26% Cutting; 11 % Other; 3 % Multiple Methods
Medical Severity	38% Mild; 39% Moderate; 14% Severe; 6% None; 3% Unknown
Victim's Intent	39% Mild; 29% Moderate; 25% Severe; 7% Unknown
Duty Environment	91% Garrison; 8% Deployed; 1% Training
Prior History of Attempts	57% None; 37% prior history (18% attempted in the past year); 4% Unknown
Communicated Intent	39% None; 17% Friend/Coworker; 7% Family; 20% Other; 16% Unknown
Resides with	40% Alone; 19% Spouse or children; 13% Barracks Roommate; 14% Other; 14% Unknown
Location of Event	47% Barracks; 20% Personal Residence; 12% Other; 21% Unknown
Time in Country	55% in country 1 year or less
Life Problems	Relationship (58%), work (56%) and military issues (33%) were the predominant life problems reported, with the majority occurring within 3 months of the suicide event
Clinical Diagnoses	Personality Disorder (43%), Alcohol Abuse (38%), Adjustment Disorder (24%), and Mood Disorder (20%) were the predominant diagnoses

(Definition of Medical Severity: Mild - superficial, transient, or self-limited event, Moderate - required treatment, but not life threatening, Severe - was likely to be fatal without treatment. Definition of Victim's Intent: Mild - self-injury with primary goal to receive attention or assistance, Moderate - self-injury with primary goal to harm self, Severe - self-injury with primary goal to kill self)

Appendix B – Figures

Figure 1: US Civilian, Army and USAREUR Suicide Completion Rates from 1996-2001

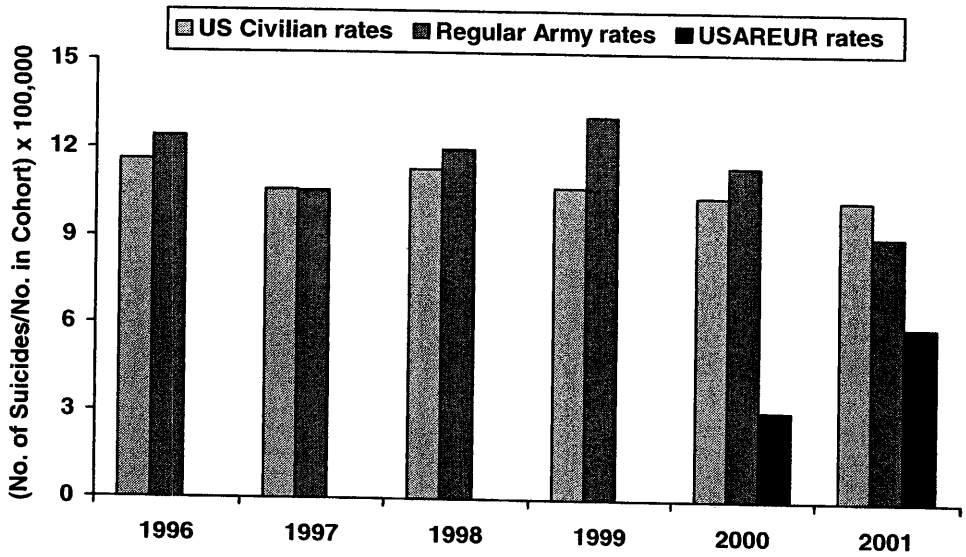
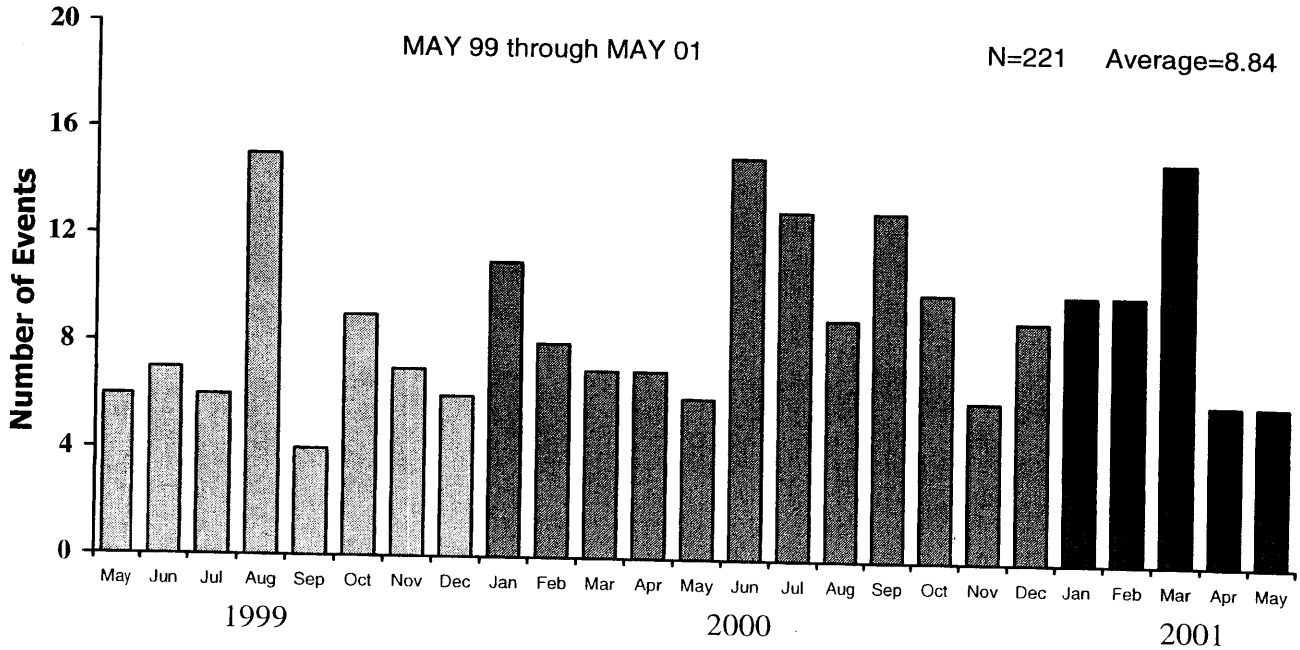


Figure 2: Pre-surveillance: Number of Events per Month



Appendix B – Figures cont.

Figure 3: Pre-surveillance: Monthly incidence rates

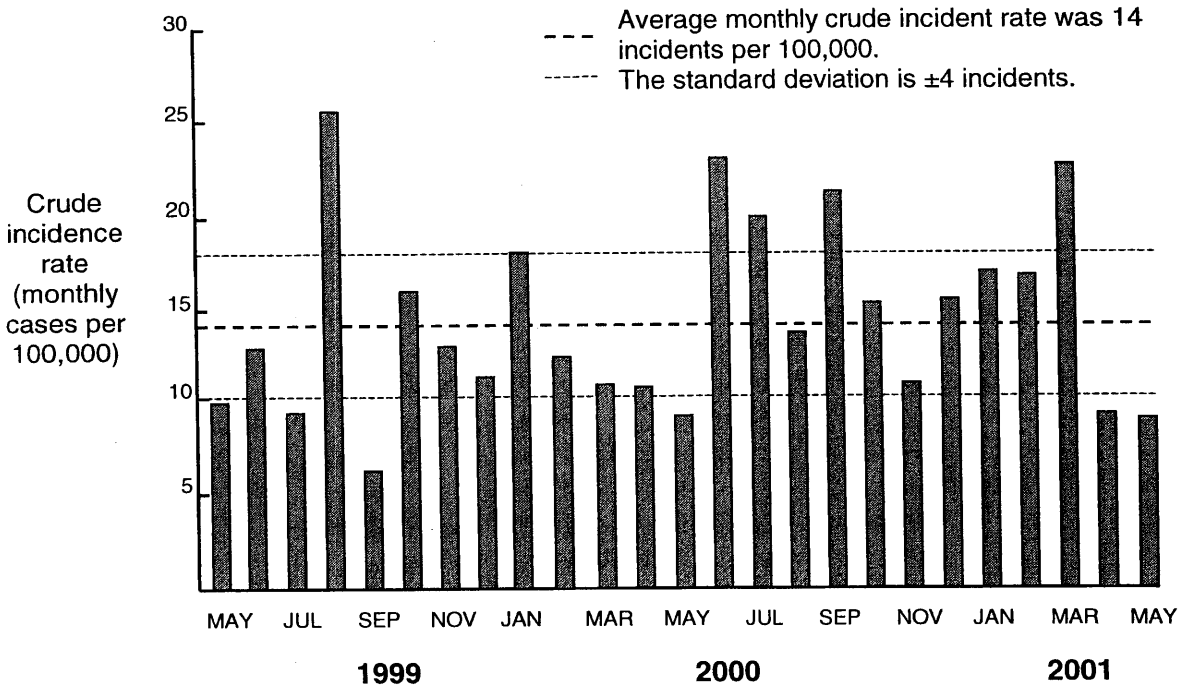
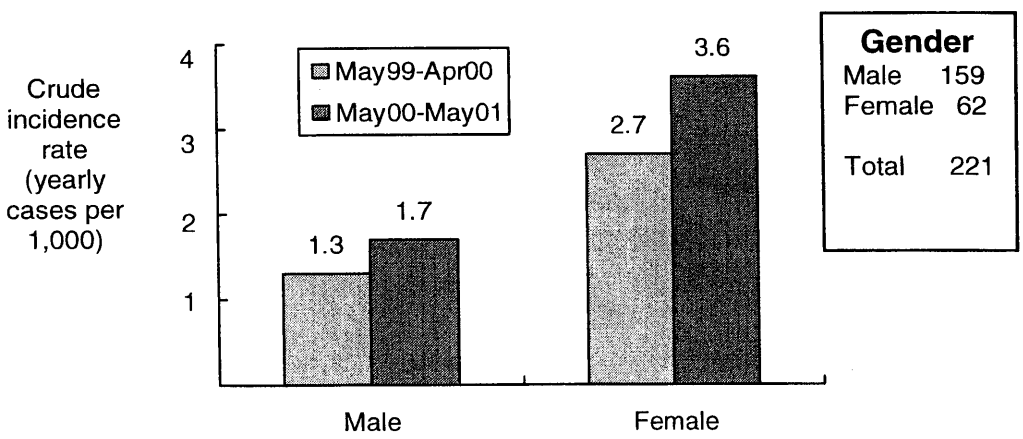


Figure 4: Incidence by gender



Appendix B – Figures cont.

Figure 5: Incidence rates by rank

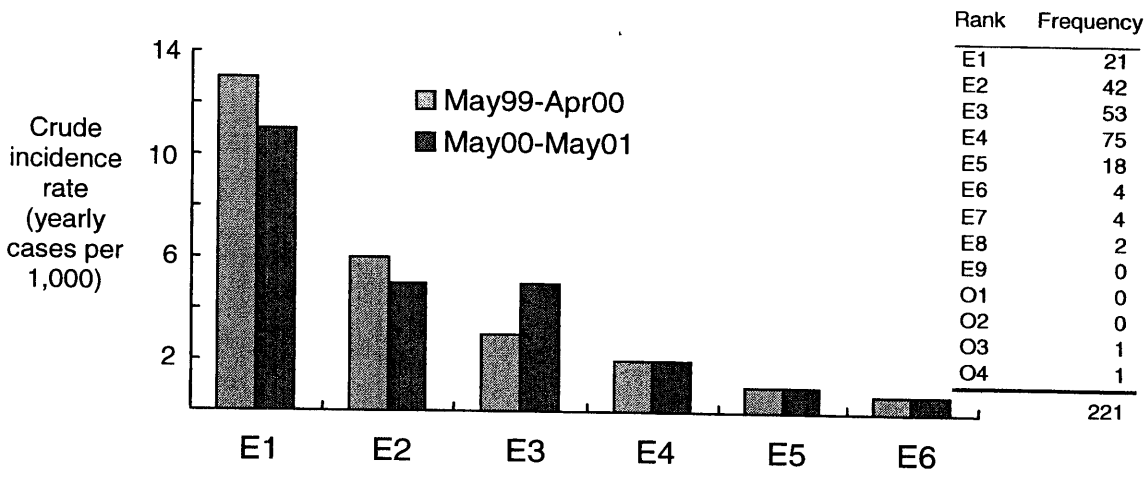
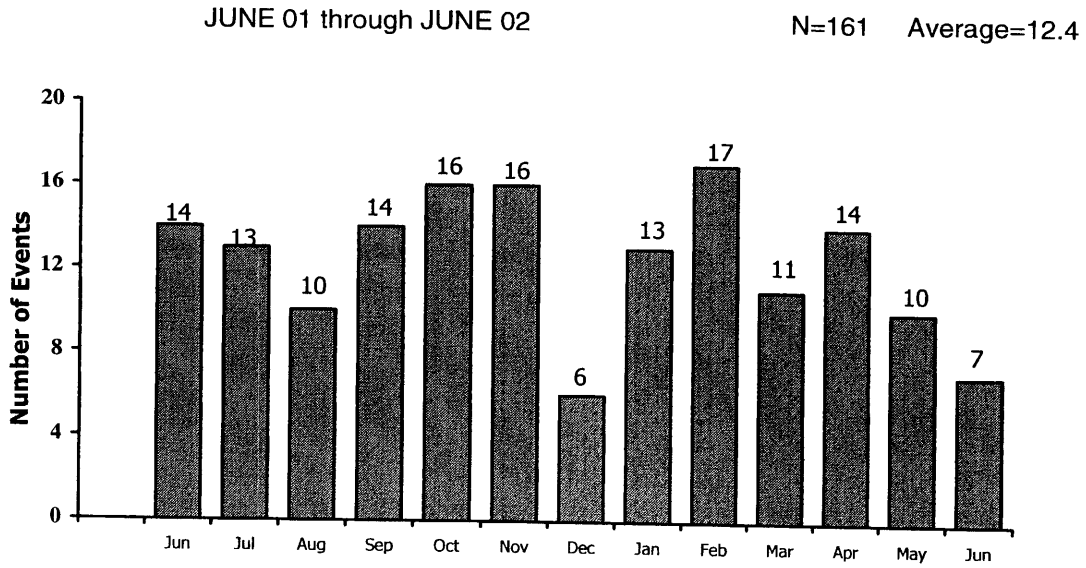


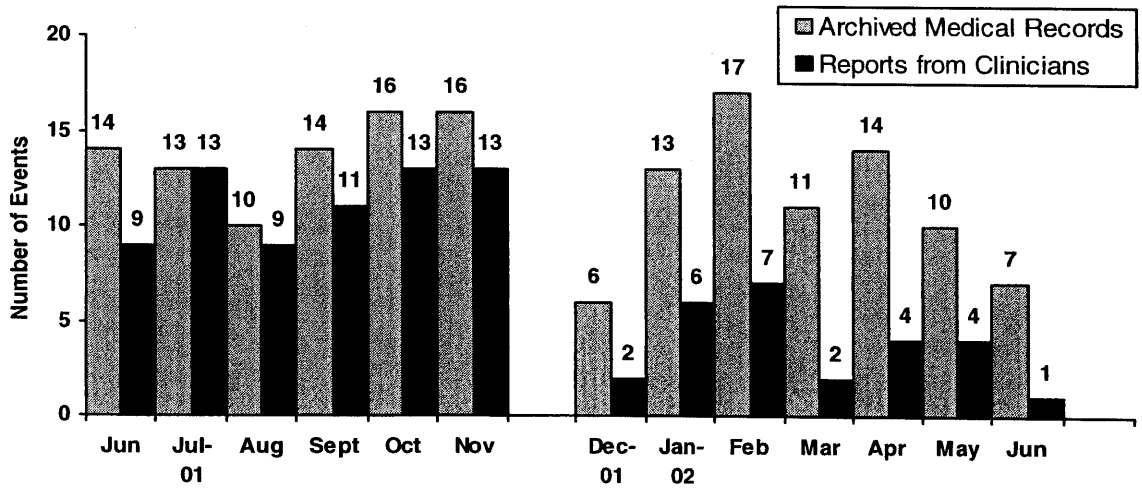
Figure 6: Surveillance: Number of Events per Month



Appendix B – Figures cont.

Figure 7: Surveillance: Response Rates – June 2001 through June 2002

Time Period:	1st Six Months	2nd Six Months
Suicide events	83	71
Forms Received	68	25



Appendix C – Guidelines for Evaluating Surveillance Systems

Prepared by Douglas N. Klaucke, M.D.* James W. Buehler, M.D.* Stephen B. Thacker, M.D.** R. Gibson Parrish, M.D.** Frederick L. Trowbridge, M.D.*** Ruth L. Berkelman, M.D.* and the Surveillance Coordination Group, Centers for Disease Control and Prevention. (*Epidemiology Program Office, CDC **Center for Environmental Health and Injury Control, CDC ***Center for Health Promotion and Education, CDC)

INTRODUCTION

Surveillance is the ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event. This information is used for planning, implementing, and evaluating public health interventions and programs. Surveillance data are used both to determine the need for public health action and to assess the effectiveness of programs.

OUTLINE OF TASKS FOR EVALUATING A SURVEILLANCE SYSTEM

A. Describe the public health importance of the health event. The following are the three most important categories to consider:
    1. Total number of cases, incidence, and prevalence
    2. Indices of severity such as the mortality rate and the case-fatality ratio
    3. Preventability
B. Describe the system to be evaluated.
    1. List the objectives of the system.
    2. Describe the health event(s) under surveillance. State the case definition for each health event.
    3. Draw a flow chart of the system.
    4. Describe the components and operation of the system.
        a. What is the population under surveillance?
        b. What is the period of time of the data collection?
        c. What information is collected?
        d. Who provides the surveillance information?
        e. How is the information transferred?
        f. How is the information stored?
        g. Who analyzes the data?
        h. How are the data analyzed and how often?
        i. How often are reports disseminated? To whom are reports distributed?
C. Indicate the level of usefulness by describing actions taken as a result of the data from the surveillance system. Characterize the entities that have used the data to make decisions and take actions. List other anticipated uses of the data.
D. Evaluate the system for each of the following attributes:
    1. Simplicity
    2. Flexibility
    3. Acceptability
    4. Sensitivity

Appendix C – Guidelines for Evaluating Surveillance Systems cont.

5. Representativeness
6. Timeliness

E. Describe the resources used to operate the system (direct costs).
F. List your conclusions and recommendations. State whether the system is meeting its objectives, and address the need to continue and/or modify the surveillance system.

SYSTEM ATTRIBUTES FOR EVALUATION

a. **Simplicity** refers to both its structure and ease of operation. Surveillance systems should be as simple as possible while still meeting their objectives. Amount and type of information necessary to establish the diagnosis
   i. Number and type of reporting sources
   ii. Method(s) of transmitting case information/data
   iii. Number of organizations involved in receiving case reports
   iv. Staff training requirements
   v. Type and extent of data analysis
   vi. Number and type of users of compiled case information
   vii. Method of distributing reports or case information to these users
b. **Flexibility** refers to the degree to which the system can adapt to changing information needs or operating conditions with little additional cost in time, personnel, or allocated funds.
c. **Acceptability** reflects the willingness of individuals and organizations to participate in the surveillance system
   i. Subject or agency participation rates
   ii. If participation is high, how quickly it was achieved
   iii. Interview completion rates and question refusal rates
   iv. Completeness of report forms
   v. Physician, laboratory, or hospital/facility reporting rates
   vi. Timeliness of reporting
d. **Sensitivity** of a surveillance system can be considered on two levels. First, at the level of case reporting, the proportion of cases of a disease or health condition detected by the surveillance system can be evaluated. Second, the system can be evaluated for its ability to detect epidemics
e. **Representativeness** is assessed by comparing the characteristics of reported events to all such actual events.
f. **Timeliness** reflects the speed or delay between steps in a surveillance system

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Entire report available at:

http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00001769.htm

Appendix D – Form 1: SPTF form June 2001

Investigation Form for Completed Suicides and Nonfatal Self-Injurious Events

Identification Information

Only people who have access to care in a military facility (those whose records can be accessed) should be entered.

Type of Event

- O Completed suicide
- O Nonfatal self-injurious event (any intentional injury to the self that did not result in death)
- O Other significant attempt to harm self

Specify: _____

Event Date (mm/dd/yyyy)

Personal Information

Date of Birth (mm/dd/yyyy)

Race

- O American Indian/Alaskan
- O Asian/Pacific Islander
- O Black (non-Hispanic)
- O Hispanic
- O White (non-Hispanic)
- O Other _____
- O Unknown

Gender

- O Male
- O Female

Marital Status

- O Single (never married)
- O Married (includes separated but not legally separated)
- O Legally separated
- O Divorced
- O Widowed
- O Annulled
- O Unknown

Ethnic Group

- O Chinese
- O Asian-American
- O Mexican-American
- O Spanish Descent
- O Cuban Descent
- O Puerto Rican
- O None
- O Other _____
- O Japanese
- O Korean
- O Filipino
- O Eskimo
- O Aleut
- O Unknown

Resides With

- O Alone
- O Spouse or Partner (without children)
- O Parents (biological, step, or adoptive)
- O Father Only
- O Friend (opposite sex)
- O Unknown
- O Spouse or Partner (with children)
- O Children Only
- O Mother Only
- O Friend (same sex)
- O Other _____

June 2001 version

Military Information

If the victim is a dependent, the following questions apply to the victim's sponsor.

Military Service	Military Status

Event Information

Medical Severity of Event

- O None
- O Mild (superficial, transient, or self-limited event)
- O Moderate (required treatment, but was not life-threatening)
- O Severe (was likely to be fatal without treatment)
- O Unknown

Victim's Intent

- O Mild (self-injury with primary goal to receive attention or assistance)
- O Moderate (self-injury with primary goal to harm self)
- O Severe (self-injury with primary goal to kill self)
- O Unknown

Communicated Intent To

- O No one (do not use for suicide)
- O Family member
- O Friend or coworker
- O Helping services
- O Supervisory chain
- O Other _____
- O Unknown

General Location of Event

- O On post
- O Off post
- O Unknown

Specific Location of Event

- O Personal residence
- O Barracks
- O Temporary lodging (hotel/motel/billeting)
- O Victim's workplace
- O Public area, common
- O Public area isolated
- O Medical facility
- O Confinement facility
- O Other _____
- O Unknown

Primary Method Used

- O Cutting or piercing instrument
- O Firearm or explosive
- O Hanging, strangulation, or suffocation
- O Jumping from a high place
- O Motor vehicle crash
- O Poisoning by utility gas
- O Poisoning by vehicle exhaust
- O Poisoning by solid or liquid substance (overdose)
- O Submersion (drowning)
- O Other _____
- O Unknown

Firearm Type (if applicable)	Firearm Source (if applicable)
O Handgun	O Military issue
O Rifle	O Privately owned
O Shotgun	O Unknown
O Other _____	
O Unknown	

Were Drugs (Illicit, Prescription, or Over-the-counter) Used During the Event

- O Yes (confirmed by toxicology screen)
- O Likely (suspected because of presence at the site or interview(s); toxicology screen not performed)
- O Unlikely (not suspected; toxicology screen not performed)
- O No (negative toxicology screen)

Specify Drugs (if applicable and if known)

_____

Was Alcohol Used During the Event

- O Likely (suspected because of presence at the site or interview(s); blood alcohol level not performed
- O Unlikely (not suspected; blood alcohol level not performed)
- O No (blood alcohol level < 0.01 g/dl)

Blood Alcohol Level (g/dl) _____

Use of Military Helping Services

Records from each agency must be reviewed for one year prior to the event.

Within the past year, was the individual seen by any of the following helping services?

Medical Treatment Facility

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Exceptional Family Member Program

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Mental Health

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Family Support

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Substance Abuse Services

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Financial Counseling

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Family Advocacy

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Child and Youth Development Program

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Chaplain

	If yes, when?
O Yes	O Within 1 month of the event?
O No	O 1-3 months prior to the event?
O Unknown	O 3-12 months prior to the event?

Risk Factors of Victim

Medical and mental health records for one year prior to the event must be reviewed.
Also, interview the victim, a surviving family member and/or others as needed.

Within the past year, did the individual have any of the following problems?

Previous Nonfatal Self-Injurious Events

O Yes If yes, when?
O No O Was it within the last 3 months?
O Unknown

Number of known previous attempts: _____

Victim of Abuse or Sexual Assault

(i.e., emotional abuse, physical abuse, domestic violence, or sexual assault)
O Yes If yes, when?
O No O Was it within the last 3 months?
O Unknown

Psychotic Disorder

(i.e., schizophrenia, schizoaffective disorder, delusional disorder, brief psychotic reaction, schizophreniform disorder, or strong suspicion of a psychotic disorder)
O Yes If yes, when?
O No O Was it within the last 3 months?
O Unknown

Military Legal or Administrative Problems

(i.e., court martial, Article 15, involuntary discharge, unfavorable information file, AWOL or desertion, EEO or EOT complaint, or other military legal or administrative problem)
O Yes If yes, when?
O No O Was it within the last 3 months?
O Unknown

Anxiety Disorder

(i.e., panic disorder, panic attacks, agoraphobia, specific phobia, social phobia, posttraumatic stress disorder, acute stress disorder, or strong suspicion of an anxiety disorder)
O Yes If yes, when?
O No O Was it within the past 3 months?
O Unknown

Under Investigation or Apprehension

(i.e., IG or unit/command-directed inquiry, AFOSI investigation, civilian investigation, or SP investigation)
O Yes If yes, when?
O No O Was it within the past 3 months?
O Unknown

Personality Disorder

(i.e., borderline, paranoid, schizoid, schizotypal, antisocial, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive, or strong suspicion of a personality disorder)
O Yes If yes, when?
O No O Was it within the past 3 months?
O Unknown

Civil Legal Problems

(i.e., divorce, child custody dispute, bankruptcy, civil trial, or other civil legal problem)
O Yes If yes, when?
O No O Was it within the past 3 months?
O Unknown

Bereavement

(i.e., death of a loved one)
O Yes If yes, when?
O No O Was it within the past 3 months?
O Unknown

Financial Difficulties

(i.e., gambling, indebtedness)
O Yes If yes, when?
O No O Was it within the past 3 months?
O Unknown

Within the past year, did the individual have any of the following problems?

Medical Problems	Job Loss
(i.e., history of chronic illness or severe physical illness) O Yes If yes, when? O No O Was it within the last 3 months? O Unknown	(i.e., involuntary separation, laid-off, relieved of duty, fired) O Yes If yes, when? O No O Was it within the last 3 months? O Unknown
Alcohol Abuse	**Work Problems**
(i.e., alcoholism or binge drinking) O Yes If yes, when? O No O Was it within the last 3 months? O Unknown	(i.e., work dissatisfaction, problems with supervisor or coworker, poor performance review, not selected for promotion, or other work problems) O Yes If yes, when? O No O Was it within the last 3 months? O Unknown
Illegal Drug Abuse	**Marital, Family, or Relationship Problems**
O Yes If yes, when? O No O Was it within the past 3 months? O Unknown	O Yes If yes, when? O No O Was it within the past 3 months? O Unknown
Prescription Drug Abuse	**School Problems**
O Yes If yes, when? O No O Was it within the past 3 months? O Unknown	O Yes If yes, when? O No O Was it within the past 3 months? O Unknown
Criminal Acts	**Other Risk Factors**
(i.e., collateral homicide, sexual misconduct, traffic-related, narcotics, crimes against person/property, criminal trial, or other criminal acts) O Yes If yes, when? O No O Was it within the past 3 months? O Unknown	

Disposition at Two Weeks After the Event

(only for victims of nonfatal self-injurious events or other significant attempts to harm self)

Days Admitted to MTF:	Disposition
Days Quarters:	Select each that apply: O Returned to duty O Restricted duty O Job transfer O Medically retired O Medically evacuated O Unknown
Days Limited Duty:	

Print Name and Signature of Individual Who Collected This Information (for future reference in your institution)	Phone Number of Individual Who Collected This Information

Comments: Please comment on any aspect of this case (i.e., information that you believe is important but was not requested)

Appendix E – Form 2: SPTF form Aug 2001

Investigation Form for Completed Suicides and Nonfatal Self-Injurious Events

Identification Information

Only people who have access to care in a military facility (those whose records can be accessed) should be included.

Type of Event

- O **Completed suicide**
- O **Nonfatal self-injurious event** (any intentional injury to the self that did not result in death)
- O **Self-Mutilating Behavior**
- O **Other significant attempt to harm self,**
  Specify: _____

Event Date (dd/mm/yyyy)

Personal Information

Date of Birth (dd/mm/yyyy)

_____

Gender

- O **Male**
- O **Female**

Race

- O **American Indian/Alaskan**
- O **Asian/Pacific Islander**
- O **Black** (non-Hispanic)
- O **Hispanic**
- O **White** (non-Hispanic)
- O **Other, Specify:** _____
- O **Unknown**

Marital Status

- O **Single** (never married)
- O **Married** (includes separated but not legally separated)
- O **Legally separated**
- O **Divorced**
- O **Widowed**
- O **Annulled**
- O **Unknown**

Ethnic Group

- O **Chinese**
- O **Asian-American**
- O **Mexican-American**
- O **Spanish Descent**
- O **Cuban Descent**
- O **Puerto Rican**
- O **Other, Specify:** _____
- O **None**
- O **Japanese**
- O **Korean**
- O **Filipino**
- O **Eskimo**
- O **Aleut**
- O **Unknown**

Resides With

- O **Alone**
- O **Spouse or Partner** (with children)
- O **Spouse or Partner** (without children)
- O **Spouse or Partner** (unknown with children)
- O **Children Only**
- O **Barracks Roommate**
- O Friend (opposite sex)
- O Friend (same sex)
- O **Parents** (biological, step, or adoptive)
- O Father Only
- O Mother Only
- O Other, Specify: _____
- O Unknown

Military Information

When the victim is a family member the following information applies to the victim's sponsor, except for Military Status of Victim.

Military Service

- O Army
- O Marine Corps
- O Coast Guard
- O Public Health Service
- O National Oceanic & Atmospheric Administration (NOAA)
- O Unknown
- O Air Force
- O Navy
- O Foreign military
- O Veteran's Administration
- O Uniformed Services Treatment Facility (USTF)
- O Department of Defense (DoD) Civilian Personnel

Grade and Rank

- O E
- O O
- O W

- O 1
- O 2
- O 3
- O 4
- O 5
- O 6
- O 7
- O 8
- O 9

Rank: _____

Duty Status

(Not applicable if sponsor or victim retired.)

- O Present for duty
- O Temporary duty (TDY)
- O Annual tour of duty (National Guard or Reserve only)
- O Ordinary leave
- O Terminal leave
- O Other, Specify: _____
- O Unknown

Duty Environment *(Not applicable if sponsor or victim retired.)*

- O Garrison
- O Training
- O Deployment, Location: _____

Deployment: If victim or sponsor was deployed, select one if applicable to the event.

- O Event occurred 60 days prior to deployment of victim or sponsor
- O Event occurred 60 days after victim or sponsor returned from deployment

Job Title: _____

MOS (Military Occupation Specialty Code): _____

Unit: _____

Permanent Duty Station (base/post): _____

Length of time in unit (i.e., 1 year 4 months): _____

Length of time in service (i.e., 2 years 2 months): _____

Temporary Duty Station (if TDY at the time of the event): _____

Military Status of Victim

- O Active Duty
- O Basic trainee
- O National Guard
- O Reserve
- O Retired
- O USMA cadet
- O ROTC cadet
- O Family member of active duty
- O Family member of retired/deceased
- O Family member of non-military personnel
- O Unknown

MACOM of Unit (MACOM to which the Unit belongs)

(Not applicable if sponsor or victim retired.)

- O USAREUR & 7th Army
- O US ARMY South
- O US ARMY Pacific
- O Criminal Investigation Com
- O Intelligence & Security Com
- O Space & Missile Defense
- O Test & Evaluation Com
- O FORSCOM
- O TRADOC
- O HQDA
- O EIGHTH US Army
- O Special Operation Com
- O Mil Traffic Management
- O MEDCOM
- O Military District Wash.
- O US Army Signal Center
- O USMA
- O US Army Material Com
- O Corps of Engineers
- O Other, Specify: _____
- O Unknown

Event Information

Medical Severity of Event

- O **None**
- O **Mild** (superficial, transient, or self-limited event)
- O **Moderate** (required treatment, but was not life-threatening)
- O **Severe** (was likely to be fatal without treatment)
- O **Unknown**

Victim's Intent

- O **Mild** (self-injury with primary goal to receive attention or assistance)
- O **Moderate** (self-injury with primary goal to harm self)
- O **Severe** (self-injury with primary goal to kill self)
- O **Unknown**

Communicated Intent To

- O **No one** (do not use for completed suicide)
- O **Family member**
- O **Friend or coworker**
- O **Helping services**
- O **Supervisory chain**
- O **Found Suicide Note**
- O **Other, Specify:** _____
- O **Unknown**

General Location of Event

- O **On post**
- O **Off post**
- O **Unknown**

Specific Location of Event

- O **Personal Residence**
- O **Barracks**
- O **Temporary lodging** (hotel/motel/billeting)
- O **Victim's workplace**
- O **Public area, common**
- O **Public area, isolated**
- O **Medical facility**
- O **Confinement facility**
- O **Other, Specify:** _____
- O **Unknown**

Primary Method Used

- O **Cutting or piercing instrument**
- O **Firearm or explosive**
- O **Hanging, strangulation, or suffocation**
- O **Jumping from a high place**
- O **Motor vehicle crash**
- O **Poisoning by utility gas**
- O **Poisoning by vehicle exhaust**
- O **Poisoning by solid or liquid substance** (overdose), **Specify substance(s):** _____
- O **Submersion** (drowning)
- O **Other, Specify:** _____
- O **Unknown**

Were Drugs (Illicit, Prescription, or Over-the-Counter) Used During the Event

- O **Yes** (confirmed by toxicology screen),
- O **Likely** (suspected because of presence at the site or interview(s); toxicology screen not performed)
- O **Unlikely** (not suspected; toxicology screen not performed)
- O **No** (negative toxicology screen)

Was Alcohol Used During the Event

- O **Yes** (confirmed by toxicology screen), **Blood alcohol level (g/dl):** _____
- O **Likely** (suspected because of presence at the site or interview(s); blood alcohol level not performed)
- O **Unlikely** (not suspected)
- O **No** (blood alcohol level <0.01 g/dl)

Firearm Type (if applicable)

- O **Handgun**
- O **Rifle**
- O **Shotgun**
- O **Other, Specify:** _____
- O **Unknown**

Firearm Source (if applicable)

- O **Military Issue**
- O **Privately Owned**
- O **Unknown**

Use of Military Helping Services

Records from each agency must be reviewed for one year prior to the event.

Within the past year, was the individual seen by any of the following helping services?

Medical Treatment Facility

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Specify problem(s): _____

Exceptional Family Member Program

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Specify problem(s): _____

Substance Abuse Services

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Specify problem(s): _____

Family Support

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Specify problem(s): _____

Family Advocacy

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Specify problem(s): _____

Financial Counseling

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Specify problem(s): _____

Mental Health (Out-Patient)

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Specify problem(s): _____

Child and Youth Development Program

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Specify problem(s): _____

In-Patient Psychiatric Admission(s)

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?
O Prior History, more than a year

Specify date(s): _____
Specify problem(s): _____

Chaplain

O Yes
O No
O Unknown

If yes, when?
O Within 1 month of the event?
O 1-3 months prior to the event?
O 4-12 months prior to the event?

Risk Factors of Victim

Medical and mental health records for one year prior to the event must be reviewed.
Also, interview the victim, a surviving family member, and/or others as needed.

Is the problem current, happened within the past year, or a part of any prior history?

Previous Nonfatal Self-injurious Events

- O Yes
- O No
- O Unknown

If yes, when and what?
- O Within 3 months of event?
- O Within 4-12 months of event?
- O Prior Suicide Attempt History
- O Prior Self-mutilation History

Number of known previous suicide attempt(s): _____

Victim of Abuse or Sexual Assault

(i.e. emotional abuse, physical abuse, sexual abuse, domestic violence, sexual assault, or sexual harassment)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?
- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Mood Disorder

(i.e. major depressive disorder, dysthymia, bipolar I, bipolar II, cyclothymia, or strong suspicion of a mood disorder)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?
- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Anxiety Disorder

(i.e. panic, agoraphobia, specific phobia, social phobia, obsessive-compulsive, posttraumatic stress, acute stress, generalized anxiety, or strong suspicion of an anxiety disorder)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?
- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Personality Disorder

(i.e. borderline, paranoid, schizoid, schizotypal, antisocial, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive, or strong suspicion of a personality disorder)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?
- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Psychotic Disorder

(i.e. schizophrenia, schizoaffective, delusional, brief psychotic, schizophreniform, shared psychotic, or strong suspicion of a psychotic disorder)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?
- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Substance Abuse

(i.e. alcohol, illegal drug, prescription drug, over the counter drug, or strong suspicion of a substance abuse problem)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?
- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Other Disorders

(i.e. adjustment, attention-deficit and disruptive behavior, eating, sexual and gender identity, somatoform, or specify a disorder not listed)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?
- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Is the problem current, happened within the past year, or a part of any prior history?

Military Legal or Administrative Problems

(i.e. court martial, Article 15, involuntary discharge, unfavorable information file, AWOL or desertion, EEO or EOT complaint, or other military legal or administrative problem)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?

- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Under Investigation or Apprehension

(i.e. IG or unit/command-directed inquiry, AFOSI or CID investigation, civilian investigation, or MP or SP investigation)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?

- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Civil Legal Problems

(i.e. divorce, child custody dispute, bankruptcy, civil trial, or other civil legal problems)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?

- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Job Loss

(i.e. involuntary separation, laid-off, relieved of duty, fired)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?

- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Criminal Acts

(i.e. collateral homicide, sexual misconduct, traffic-related, narcotics, crimes against person/property, criminal trial, or other criminal acts)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?

- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Work Problems

(i.e. work dissatisfaction, problems with supervisor or coworker, poor performance review, not selected for promotion, or other work problems)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?

- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Financial Difficulties

(i.e. gambling, indebtedness)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?

- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Medical Problems

(i.e. history of chronic illness or severe physical illness)

Specify: _____

- O Yes
- O No
- O Unknown

If yes, when?

- O Within 3 months of event?
- O Within 4-12 months of event?
- O More than 1 year from event (Any Prior History)

Is the problem current, happened within the past year, or a part of any prior history?

Bereavement	Marital, Family, or Relationship Problems
(i.e. death of a loved one) Specify: _____ O Yes O No O Unknown If yes, when? O Within 3 months of event? O Within 4-12 months of event? O More than 1 year from event (Any Prior History)	Specify: _____ O Yes O No O Unknown If yes, when? O Within 3 months of event? O Within 4-12 months of event? O More than 1 year from event (Any Prior History)
School Problems	**Other Risk Factors**
Specify: _____ O Yes O No O Unknown If yes, when? O Within 3 months of event? O Within 4-12 months of event? O More than 1 year from event (Any Prior History)	Specify: _____ _____ _____ _____ _____

Initial Disposition (within 72 hours of the event)
Treatment status at the time this investigation form was completed.

- O Admitted to LRMC In-Patient Psychiatric Unit
- O Medically evacuated to local civilian hospital
- O Medically evacuated, Specify: _____
- O Restricted duty
- O Returned to duty
- O Returned Home (other than military personnel)
- O Other, Specify: _____

Name and signature of individual who collected information	Date information collected and contact's phone number
Print Name: _____ Signature: _____	Date: _____ Phone number: _____

Comments: Please comment on any aspect of this case (i.e., information that you believe is important but was not requested)

Final Disposition at Two Weeks After the Event

Date Admitted to MTF: _____

Date Discharged from MTF: _____

Number of days on:

Leave: _____

Limited duty: _____

Quarters: _____

Select each that apply:

- O **Returned to duty**
- O **Restricted duty**
- O **Job transfer**
- O **Medically retired.** Specify chapter: _____
- O **Medically evacuated.** Location of further treatment: _____
- O **Returned Home** (other than military personnel)
- O **Other, Specify:** _____
- O **Unknown**

Appendix F – AMEDD Suicide Event Report (ASER)

***** SENSITIVE INFORMATION / CLOSE HOLD *****

AMEDD Suicide Event Report (ASER)

PILOT VERSION – v. 21 May 2002
(please direct any suggested improvements to: David.Orman@amedd.army.mil)

HQ, USA MEDCOM, ATTN: MCHO-CL-H
Behavioral Health Division
Health Policy & Services
2050 Worth Road
Fort Sam Houston, TX 78234-6010

Sensitive Information / Close Hold

AMEDD SUICIDE EVENT REPORT (ASER)

The Army Medical Department(AMEDD) appreciates your assistance in completing this form regarding a recent *active duty soldier's - suicide event. As most of you well know, completed suicide is one of the leading causes of death among U.S. soldiers, and suicide attempts requiring hospitalization are an antecedent factor in premature attrition and potentially avoidable soldier suffering. This report attempts to succinctly standardize the data collected on these suicide events, and is an integral part of the Army's Suicide Prevention Program. Data from Part I of this form is automated for use in suicide prevention program evaluation, analysis, and improvement. Part II is for QI/PI.

This form is not intended to replace the psychological autopsy(PA), however under the new DoD/Army policy, *psychological autopsies will be limited to those cases in which the manner of death is* equivocal. For most suicides events/completions, in which the manner of self-injurious behavior/death is NOT in question, this form will be sufficient to convey the important elements of each case. The purpose is to provide Army leaders/policy makers, and the AMEDD with standardized data on each suicide event for purposes of suicide prevention program/clinical care improvement and systemic risk management, while keeping the time investment to a minimum for the BH provider tasked to complete. * Active duty soldiers include "activated" National Guard and USAR soldiers.

Who Completes this Form: Any credentialed behavioral health (BH) clinician, *except (if possible)* those who provided treatment to the involved patient / decedent or those who personally knew the patient / decendent.

Instructions:

Completing this form is **REQUIRED** for:
a. ONLY those nonfatal ***suicide events*** – resulting in hospitalization
b. ALL ***suicide completions*** – BOTH the EQUIVOCAL(requiring a PA) as well as the unequivocal per above

Methodology (for BOTH non-fatal suicide events & completions):

1. Review of all available medical and mental health records of the patient / decedent;
2. Interview co-workers and supervisors of patient / decedent - as needed;

For suicide completions only:
3. Review of the decedent's personnel / counseling records;
4. Interview of responsible investigative agency (CID) officer and/or review of CID records;
5. Review any other records related to manner of death (e.g. casualty report, toxicology/ lab reports, autopsy report; suicide note, etc), and enlist the assistance of professionals such as behavioral health clinicians who treated the decedent, drug and alcohol counselors, chaplain, military police, family service personnel, and others;
6. Interviews with family members are also encouraged, but are not required.

The purpose of these interviews primarily is to provide firsthand facts concerning the patient/decedent and his/her behavior, not to determine accountability or culpability for the service member's death.

If you are unable to find the answers to any given question on Part I of this form, leave blank - otherwise complete **Part I** by filling in the applicable bubbles-"O" within each informational block/section. **Part I** is **mandatory** for **all suicide completions** and **suicide events *resulting in hospitalization,*** *irrespective of prior BH clinic involvement.*

Part II – Narrative Summary, please succinctly complete the following sections on all suicide completions & ***only*** *those event hospitalizations which had prior BH clinical involvement* (includes ADAPCP, FAP, SWS, and CMHS):
a) 'sequence of events' – a brief narrative description of the relevant events culminating in the suicide behavior;
b) 'bio-psycho-social' formulation of the case which explains WHY this person perpetrated a suicide behavior;
c) 'risk management' analysis which lays out any BH involvement in the case with emphasis on any discontinuity of care or flawed clinical decision-making, AND addresses known unit leadership actions/ inactions that may have contributed to the suicide event. Part II is protected as a QI document under Federal Law and not subject to FOIA.

*** SUSPENSE for this action is 60 days from the date of attempt/death ***

Please return this form via electronic means or mail to address on cover sheet:

Behavior Health Division, HQ. MEDCOM - ATTN: COL Orman at: < **David.Orman@amedd.army.mil** >

Sensitive Information / Close Hold

AMEDD - Completed Suicide & Nonfatal Self-Injurious Event Report Form (ASER) – Part I

Identification Information: (Only DoD beneficiaries - who have access to care in a military facility should be included)

Patient's/Decedent's- **Last Name:**	Patient's/Decedent's- **SSN:**
Patient's/Decedent's- **First Name & M.I.:**	**Suicide Event Date:** (dd/mm/yyyy)
Type of Event (select one): O Completed Suicide O Nonfatal self-injurious event - *resulting in inpatient Tx* (any intentional injury to self that resulted in hospitalization)	**Medical Severity of Event:** O Self-limited event NOT requiring medical treatment O Required med treatment BUT was NOT life-threatening O Required treatment AND likely FATAL without treatment

Personal Information: (all dates on this form should be formatted as – dd/mm/yyyy, unless specified otherwise)

Date of Birth: **Gender:** O Male O Female	**Residence:** O Resides alone O Resides with others O In barracks O On-post housing O Off-post housing
Education: O<HS O HS/GED O 2yr college O college grad	
Race: O White (non-Hispanic) O Hispanic O Black (non-Hispanic) O American Indian/Alaskan O Asian/Pacific Islander O Unknown	**Marital / Parental Status:** O Single O Divorced O Married(reside with spouse) O Legally Separated O Married(geographically separated) O Unknown Does patient / decedent have children? O Yes O No

Military Information:

Military Affiliation*: O RA or O Reserves or O Natl.Grd. O Army O Family Member of Active Duty O Air Force O Retiree O Navy O Unknown O Marine Corps O DoD Civilian *(check all categories that apply)	**MOS** (Military Occupation Specialty Code): _____ **Unit**: _____ **Permanent Duty Station** (base/post) **& Unit ID Code** (UIC): _____
Date entered Basic Trng./Commissioned as Officer: (dd/mm/yyyy)	**Length of time in unit** (e.g., 1 year 4 months): _____Year(s) _____Month(s)
Grade: O Enlisted O Officer O Warrant O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9	**Deployment:** Was event related to a deployment? (including anticipated deployment or deployment that recently ended) O Yes O No If YES – Start Date of Deployment (mm/yyyy) _____/_____ End Date of Deployment (mm/yyyy) _____/_____
Duty Environment (check all that apply): O Garrison O Leave O TDY O AWOL O Deployment O Other: _____	Deployment Location: _____

Suicide Event Information:

Did victim communicate INTENT to others? O Yes O No **Victim's Intent (as judged by the clinician):** O Self-injury with primary goal to receive attention/help O Self-injury with primary goal to physically harm self O Self-injury with primary goal to kill self O Unknown	**Substance Use** (information confirmed from medical exam, toxicology screening, or victim's report) During the event - Were Drugs used? O Yes O No O Unknown Was Alcohol used O Yes O No O Unknown

Primary Method Used

O Poisoning by solid or liquid substance (overdose)	O Cutting or piercing instrument
O Firearm: O-registered or O-unregistered with post	O Poisoning by vehicle exhaust
O Jumping from high place	O Poisoning by utility gas
O Motor vehicle crash	O Submersion (drowning)
O Hanging, strangulation, or suffocation	O Unknown
O Other, Specify: _____	

Sensitive Information / Close Hold

Patient's / Decedent's Use of Medical/Helping Services and Risk Factors: **Part I**

Use of Medical/Helping Services(Code & √ all that apply):
Within the past year, was the victim seen by any of the following services? (Answer all categories with a code)
Codes: 1 = No, not within 12 months prior to event
2 = Yes, within 30 days prior to event
3 = Yes, within 31-364 days prior to event
4 = Unknown

___**Medical Treatment Facility:** O Pending MEB/EPTS
O Diagnosed with serious/chronic disease(s)

___**Substance Abuse Services:**
O Pending abuse related adverse action(s)

___**Family Advocacy Program:**
O Pending FAP-related adverse action(s)

___**Mental Health**(Out-Patient): O Psychotropic meds
O Pending administrative separation

___**In-Patient Psychiatric Admission(s):** O Psychmeds
O Pending MEB/EPTS or O Pending admin. sep.

Victim's History
Any evidence of pre- AD service mental health problems and/or treatment?
O Yes O No
Any evidence of prior suicide attempt history?
O Yes O No
Any evidence victim was a child abuse victim?
O Yes O No
Any evidence victim was troubled by childhood/pre-AD service traumatic event(s)?
O Yes O No
Explain Yes(s) above in Part II-B. of Narrative Summary.

Did patient / decedent receive emergeny medical treatment for this event? O Yes O No

Did event result in hospitalization? O Yes O No
If YES @: O MTF O Civilian Facility O VA Hosp.
Name of Facility: _____
Date of admission (dd/mm/yyyy) ____/____/____

Other Risk Factors not already addressed (list below & elaborate in Part II-B's "Biopsychosocial Formulation"):

_____

_____

Risk Factors Within the past year, was there evidence for any of the following problems? (Code & √ all that apply)
Codes: 1 = No, not within 12 months prior to event
2 = Yes, within 30 days prior to event
3 = Yes, within 31-364 days prior to event
4 = Unknown

___**Previous Known Nonfatal Self-injurious Event(s):**
O # 1 O # 2 O # 3 O # 3+

___**Psychotic Disorder (any type)**

___**Mood Disorder:** O Bipolar O Major Depression

___**Personality Disorder/Traits**(significant):
DSM-IV: O Cluster A O Cluster B O Cluster C

___**Substance Abuse**(check all that apply):

	Dependence	Abuse	Intoxication
Alcohol:	O	O	O
Drug(s):	O	O	O
Meds(prescribed):	O	O	O
OTC meds:	O	O	O

___**Victim of Abuse or Sexual Assault**(√ all that apply):
O physical O sexual O emotional/mental/verbal
O domestic violence O sexual harassment

___**Alleged Perpetrator of Abuse / Assault**(√ all that apply):
Type: O physical O sexual
Victim: O child O adult **Related:** O Yes O No

___**Military/Legal/Administrative Problems**(√ all that apply):
O courts martial O Art.15 O admin.separation
O AWOL/desertion O promotion passover O arrest

___**Work Problems**(√ all that apply):
O work dissatisfaction O supervisor/coworker issues
O poor work performance review O Other

___**Marital/Family/Relationship Problems**(√ all that apply):
O separation O divorce O separation from kids
O spousal/family death or serious illness

___**Financial Problems**(√ all that apply):
O excessive debt O bankruptcy O eviction
O gambling losses O business/personal $ losses

Completing Behavioral Health Provider's Information:

Printed Name: **Date & e-Mail Address:**

Signature: **Phone Number(commercial & DSN):**

Comments: (Please use this space to provide any suggestions you might have about how to improve this data form)

Sensitive Information / Close Hold

Part II - Narrative Summary *

This section is to be completed ONLY for:

- Suicide Completions OR
- Suicide Events (non-fatal) resulting in HOSPITALIZATION AND

In which prior to the suicide-related hospitalization, a BH clinic/provider was INVOLVED(see page 2)

. Sequence of Events culminating in the Suicide Event / Behavior:

Please describe the details of the antecedent circumstances that led to the suicide attempt/completion)

. Why did this Soldier choose to injure or kill him/herself ?

Please provide a brief "bio-psycho-social" formulation as to "WHY" this individual committed the suicide attempt/completion)

.. Risk Management Analysis:

Any BH clinical involvement – elaborate on any issue of concern. Also elaborate on unit actions that may have been of concern)

Attach additional sheets as necessary for any section above. This page is protected from Disclosure under XXXXXXXX

(Use this page for additional space needed to complete Part II - A., B. or C. on reverse)

Appendix G – Clinical Provider Interview Guide

"Thank you for taking the time to meet with us about the Suicide Program. Our unit is evaluating the pilot study you are participating in, since the program will be implemented Army wide sometime this year. With this evaluation, our unit wants to show how your contributions are key to a successful continuation of the program."

Old Form

Describe your experience with the investigation form.

What would you identify as the weaknesses?

Do you have any suggestions for improvement?

What should not be included?

What about the strengths?

What are some items that should stay in the form?

Participation in Study

Addressing your and the clinics participation in the study, what are some of the drawbacks?

What are some of the benefits?

Have you found any benefits with patient care or other issues?

Feasibility

How are your and the clinics resources being tapped to participate in the study?

How feasible (or workable) has participation been?

New Form

(*Give them new draft format*)

COL Orman, psychiatric consultant to the Surgeon General, has disseminated this form for an Army wide pilot study. Your thoughts and comments are appreciated.

Appendix H – Transcripts of Clinical Provider Interviews

Suicide surveillance system evaluation: Interview transcripts
(Time, date and identifier information have been removed)

Interview # 1
Number of forms completed by interviewee: 6

IN YOUR EXPERIENCE WITH THIS FORM, WHAT ARE ITS STRENGTHS AND WEAKNESSES?
Well, it's too long. It includes people which we don't need to study – Air Force, family members, DOD civilians. Junk in- junk out. I DON'T call social work. I don't call ACS. I don't call CCC. I don't call AFOSI or CID, so I say 'unknown, unknown, unknown.' Sometimes I say – I can't recall exactly if I say 'unknown' or 'no' – but I know that it's junk in junk out. That's the worst thing about the form is that it takes a lot of my time and my providers time, and I don't think it – I don't know what good it can help.
STRENGTHS?
There aren't any strengths to this form because you can't separate the form from the study. I'm not a researcher, I'm a clinician, but I know enough. It's not a very… I'm not sure what it's showing. The reason the army went away from requiring psychological autopsies on all suicides is, well several reasons, sometimes the data were done poorly, but there is LOTS of data. We know why people suicide! We don't need to do it anymore unless there's an equivocal death and we need to figure out if it's a suicide or homicide. So this is 'wasting our time, lite.' If Psych Autopsies for the last 5 years was 'wasting our time,' then this is 'psych autopsy lite.' It can't be of any benefit to me – we haven't seen any reports or whatever. It wasn't designed to help me, I didn't ask for it.
HOW HAS PARTICIPATING IN THE STUDY AFFECTED YOUR RESOURCES AND THOSE OF THE CLINIC IN GENERAL?
It's just an extra thing of paperwork that takes two or three emails and 5 or 10 minutes, and there's so much. By doing this, and it's not of much importance to anyone except [*leader*], it distracts me from doing other things, administratively, which supposedly are also important. It is, the bubble is something akin to reduce the hassle factor – this does not reduce the hassle factor in the ERMC strategic plan.
HAVE YOU SEEN ANY BENEFITS FOR PATIENT CARE IN DOING THIS?
Zero.
AS FAR AS PARTICIPATION, YOU SAID IT TAKES AWAY FROM OTHER THINGS THAT YOU CAN BE DOING. IS THERE ANY BENEFIT OF COLLECTING THIS INFORMATION WHEN YOU ARE WORKING WITH THE PATIENT?
I see my patient, do my clinical interview, and then I pick up this form about a day later and fill it out based on my memory and my understanding. I don't grill the patient about these specific criteria because there is so much in modern medicine these days that we have to ask that the provider feels is superfluous to the issue at hand, that I'm not going to… If it was intended to be gone over – check this, check that – then it would be even MORE disruptive to the process. Luckily this is something that I can fill out, but it doesn't help. I already have this information. I already GET this information. It's in the chart or it's in my head.

HOW FEASIBLE DO YOU THINK THIS KIND OF STUDY IS? YOU MENTIONED EARLIER THAT THIS FORM IS NOT WHAT THIS TYPE OF STUDY NEEDS.

What is the intent? What is the null hypothesis? It's not a study. It's a data collection. The premise isn't... we know why people kill themselves. The biggest problem with this is that it gives a misperception to command that we're doing something. It gives them that feel-good sense. I'm not saying that there is necessarily anything that can be done in any hierarchical level, but it gives the wrong impression to leadership if they thin we're doing right by the soldiers, by the military, and the army, the USAREUR, by doing this. It gives the wrong impression that we're taking care of the USAREUR community doing this report.

DO YOU THINK THIS LOOKS AT THE SYMPTOM RATHER THAN THE PROBLEM? IS IT GOING BACKWARDS FROM LOOKING AT WHAT CAN REALLY BE DONE ABOUT THIS TYPE OF ISSUE?

There are books; there are reams of articles written about suicide! From an academic standpoint, there are always questions you can ask and research you can do, but that should not be command's job. Command does not need to do academic, epidemiologic research on suicide. It's already been done – we know who suicides, we know the demographic. The most prudent thing is to stop it, just to chuck it. Link us up to the MedCom one and don't make it separate.

Some concrete recommendations:

Just do the army soldiers – check the family members, chuck the air force. It's not to say they're not important, but they're doing a separate study. It's like double reporting! It's silly, command looks foolish. Just focus on army. Adopt the MedCom thing. Coordinate with the psychiatry consultant or the MedCom section on mental health come and brief the leaders, and I trust they will be able to break it down by region and so forth.

If you were to maintain this, further narrow down the definition of 'any intentional injury to the self that did not result in death.' Get rid of self-mutilating behavior. That's a fad – that's 'in' now! Where is the line between that and 'non-fatal self-injurious event'? I don't know! It's just gobbledy gook! Validate the study! Assess the value. Give 10 mental health providers the same cases and provide interrater reliability – see if they rate it the same on this stuff and I bet they won't. What I suggested to the WRAIR team is that they change that to 'requires true medical treatment' – it's not just a bandage or a scratch. Sutures or something. Taking 5 aspirin doesn't require true medical treatment. What about somebody who put their hand through a wall or a locker? I don't know what that is.

I WANTED TO ASK YOU ABOUT THE NEW FORM...

OH, my same suggestions... (Reading form) He revised this a couple of times. It still says 'DOD, civilian, retiree.' Don't want to know! Ditch it. (Reading) 'Review of all available medical and mental health records' See, that's not going to happen! I'm not going to get all of those contacts. (Reading) 'Interview methodology – interview co-workers as needed' – I guess that's fair, because I'm not going to interview people for attempts. (Reading narrative) Hummm....

WHAT ARE YOUR THOUGHTS ON DOING A NARRATIVE SUMMARY ON ALL ATTEMPTS AND COMPLETIONS?

It's too much of a distracter. I guess if it's limited to admissions, but it's a HUGE percentage of inpatient docs! The patients make gestures and attempts. If they don't get too hyper and a

couple of sentences will suffice… It's too much to have it done quickly and concisely. For that matter I like ours better. It's longer, but it's do it, knock it out and you're done.
SO YOU THINK THAT WOULD BE A HINDERANCE?
Yes, it's required to do more investigation and research and it's too much!
IS THAT GOING TO PUT DEMANDS ON YOUR…
…Resources! Yes, Exactly! It doesn't help a single patient a single bit, not one single gosh darn bit! And it's redundant! I kind of have a problem with this risk management section. Risk management – that's going to be reviewed in another forum in more depth if it's appropriate. Risk management – and I don't sit on that committee – but it's a very involved, detailed committee. It's close-hold with the information and THIS is not. So you want garbage in opinions that aren't really research and potentially garbage out results. To do justice to that, it'd require… if you just want general impressionistic things it's easy, but there's a problem with that in research. It's misleading, and it doesn't have the complete facts. Don't try to make it into something that its not. I don't like that when I think about that.
I wouldn't mind doing this for the completions. I have less problems with doing that, and he really does need to include, he needs to finish the typo on the bottom of this page – but it's too much for attempts! Let me relook at it from the concept of completed suicides. You still don't need to do one for family members or the other services. This is an army thing.
This is kind of confusing – "did the event result in hospitalization" – I guess you'd mark no if it's a suicide, but otherwise, it's not being internally consistent.
Where it says, "who completes this form" he needs to clarify that! "Any credentialed health clinician who provided treatment" – it's a bit misleading. I don't think he intends to exclude the people who provide the treatment in the after evaluation. And some of our places are one man shops, and as much as he says we're inefficient here in Europe because we don't insist on people driving – well that's just how we are, so there are one-man shops, so that could be confusing.
Here where it says it requires treatment – what kind of treatment, provide examples: sutures, yes, buy a bandage and steri-strips are first aid, not treatment.

Interview # 2
Number of forms completed by interviewee: 2

IN YOUR EXPERIENCE WITH THE FORM, WHAT WOULD YOU SAY ARE ITS STRENGTHS AND WEAKNESSES?
I would say the length of it and faxing it. Usually at least one page gets faxed wrong, or you don't get it. If you call back a week later with a question, I really have to think back to remember that patient. We see so many patients! So I think it'd be helpful if you could get it on a computer where you could just 'X' and e-mail it off to you and then we could save it in a file.
WITH THE FORMS THAT YOU HAVE NOW, DO YOU KEEP THEM IN PATIENT FILES OR DO YOU KEEP THEM SEPARATE?

I keep them separate in my locked chest over here in case someone calls back. I don't do them that frequently, but when I do them I try to comment. If someone calls back 3 days later with a question. I do have a question. Who is supposed to fill it out, specifically?
THE PROVIDER.
Which provider, specifically?
WHOEVER IS SEEING THE SUICIDAL PATIENT?
To include the emergency room or family practice? That does not get done!
THAT IS AN AMBIGUITY OF THE SYSTEM. THE DIRECTION FROM HIGHER UP WAS 'WHATEVER CLINICIAN IS TREATING THE PATIENT IS SUPPOSED TO FILL OUT THE FORM.'
The 'first contact' so to speak?
HAS PARTICATION IN THE STUDY BEEN A FRUSTRATION OR DIFFICULTY?
I think you just know that if you see someone a couple of days later, you just know the ER hasn't done it, so it's probably not the first [treatment]. I guess when you think of suicide, you think of an emergency; something you really need to get to, so I think it's almost an afterthought. You know, being something of the many forms that we do fill out. It's just the length. It's not difficult to fill out, but just by chasing it in the fax machine and it's been broken – it's just those things. I think it's just administrative, I think the information and the questions that are asked are fine. I just think it could be done more easily on a computer – you can just 'X' it and send it in. Faxing just – we don't have a really great fax.
Maybe it was her, but I felt really pressured. I have it here, but I don't remember the
WHAT ABOUT ANY STRENGTHS IN THE FORM? DO YOU SEE ANYTHING THAT HAS BEEN BENIFICAIL, IN PARTICULAR WITH PATIENT CARE?
No, it's mostly demographics.
AND THE RISK FACTORS OR THE HELPING SERVICES?
I think the risk factors are important to annotate. Here there is almost never a firearm, but if you were to do this at Ft Campbell or Ft Hood, that would be huge – it'd be HUGE.
HAVE YOU HAD ANY DIFFICULTY FILLING OUT THE SECTION ON THE USE OF HELPING SERVICES?
Nope, not a problem.
DO YOU HAVE ANY SUGGESTIONS FOR IMPROVEMENT IN THE FORM?
To put it on the computer so we can e-mail it to you, and that's really it.
SO THE CONTENT SEEMS TO BE FINE?
Yup. I think you can probably derive a lot of correlations from this.
IS THERE ANYTHING THAT YOU WOULD DELETE?
I don't think so.
I think what… do you have one here… we're seeing a lot of people here with their GED. Do you have that?
THE EDUCATION? NO WE DON'T.
That's really important. We're seeing like 9th and 10th grade. Or doing stints in juvie hall – antisocial behavior as kids, especially those that are getting a chapter 14-12b – for a pattern of misconduct or patterns of misconduct. A lot of them were in juvenile hall, kicked out of school, parts of gangs.

DO YOU THINK IF THERE WERE A QUESTION ON PRIOR CRIMINAL ACTIVITY…

I'd say 'youth'. Oftentimes what happens when they come into the service is that their juvenile record is expunged. They're not lawfully required to say it, so we have people who have been doing drugs, who have been in detention centers, a lot of foster care. People that, probably under stressful situations, would not manage as well as other people. Look at the GED, that's something especially with suicidal/homicidal acts. Sometimes people who've done those juvenile criminal activities, they perpetuate as adults.
AS FAR AS PARTICIPATING IN THE STUDY, HOW HAS IT AFFECTED YOUR RESOURCES AS WELL AS THAT OF THE UNIT?
It's not huge. If the fax machine breaks, I go and use another one, but I think it certainly is a good thing to look at and compare all the data. You're touching on a lot of the characteristics – the demographics, the pre-treatment, the post-treatment, if they've sent he chaplain, what resources have they touched before they come to us. I think it's been good.
HAS IT BEEN BENEFICIAL AT ALL FOR YOUR CARE WITH PATIENTS?
I don't think it's changed. We have our own check sheet for the outpatient, and form that you derive your diagnosis and you kind of go from there. It hasn't shaped the way we treat patients.
HOW FEASIBLE WAS IT FOR YOU AS WELL AS IN THE CLINIC TO PARTICIPATE?
It's feasible.
Maybe just a gentle reminder every couple of months that it's out there any we have this, we hope that you're using it. I'm sure that there might be people that are skating through it – whether it's through the ER or told the family practice doc… those kinds of things, just gentle reminders.
THIS NEW FORM -- THERE ARE SOME CHANGES AND I'D JUST LIKE YOUR COMMENTS AFTER A BRIEF LOOK. MOST OF IT IS THE SAME, THERE ARE SOME ADDITIONS, A HISTORY AND THERE IS AN EDUCATION QUESTION ON THERE. THE LAST PART IS COMPLETELY DIFFERENT AND THERE IS A NARRATIVE SECTION.
Yup, yup! That's good! I can type quicker than I can write, so if I could do it on computer, I could get that out. I think the narrative part adds a qualitative aspect. Sure!
DO YOU SEE THIS AS BETTER OR JUST DIFFERENT FROM WHAT YOU'RE USING NOW?
I'd have to look at them side-by-side. This one looks shorter, but also more compact. I see the stuff on the pre-victims history, but it's not spelled out. If you don't say "have you ever done juvenile hall time? Were you ever expelled from school for whatever?' they will circle 'no.' But I see the 'perpetrator or victim of abuse' – that kind of thing, I think that's good.
And the codes – if you're seeing someone for the first time, it'd be difficult to say if they were bi-polar, major depression, or with a personality disorder. I don't know if you could answer that because when we initially do an intake, we usually defer and we find out after their personality comes out. I don't know that this is even needed unless it's per history or previously diagnosed. A patient is not going to say "I am a cluster A or a cluster b".
Financial problems – that's a good one.
Is it hard if you're switching from one [form] to the other – do you change course with information you have?

Appendix H – Transcripts of Clinical Provider Interviews cont.

Interview # 3
Number of forms completed by interviewee: 16

LET'S START BY TALKING ABOUT THAT FORM YOU HAVE FIRST, THEN WE'LL LOOK AT THE NEW FORM. SPECIFICALLY, CAN YOU START BY TELLING ME THE POSITIVES AND THE NEGATIVES OF THAT FORM, AND WITH ANY NEGATIVES, TELL US ANY SUGGESTIONS FOR IMPROVEMENT?
The negatives – maybe not a negative per se – but it's too lengthy. It's hard for the provider – for instance if you were meeting a patient in the emergency room, there's no way you could do it, it's too lengthy.
Going through another 7-page thing, it's hard. It's hard on anybody. Even when you are seeing a patient on the ward, you know you have to do the intake, it's easier to do it on the ward, but again on the ward it gets pretty busy. You can have five new admissions to see. On the outpatient we have about 30 or 40 minutes to do everything and to get the patient on the ward because you've been on call.
ARE THERE ANY SECTIONS THAT YOU FOUND MORE DIFFICULT THAN OTHERS?
Not really. There are some sections that I like about this. The military information, I think it's very good. 'Where the incident took place,' for instance, was it in the barracks, was it was in the field. If you could get the unit, more units have cases – depending on the MOS – have more cases than others. So it's interesting if you have any peaks in certain units that show up more than others. This one here I never quite understood – MACOM of unit. This is very hard, I have no idea. The job title – those are important things but when you have limited time, it's hard. You may need the soldier with you as you're doing this. The event information is very good, the communication, if the intent was communicated to anybody. If alcohol or drugs were used during the event. The use of military helping services, I like that. It kind of gives you an overall picture, because it's not just one thing.
DID YOU HAVE DIFFICULTY WITH THAT SECTION? I KNOW IT USUALLY REQUIRES MORE TIME…
No, I never really had. Usually when I'm talking to the patient, in any setting, I had always asked if they ever had a family advocacy referral, for example. Usually they tell me if they had financial counseling, or financial problems. You usually have an idea if they are going out a lot, wearing very trendy clothes – where are they getting their money? How much money are you spending drinking? I'm sure they are going to have some financial problems. This section here – the risk factors – should not be a problem because when you are interviewing someone you really need to go into their past history, especially psychiatric history, were you ever diagnosed with anything? Have you ever been taken care of by a psychiatrist? So this is very easy to answer, on both sections. It takes me, for the page, that's not a problem, but still it's quite lengthy.
HOW MUCH TIME DO YOU THINK YOU SPEND FILLING OUT THIS FORM RIGHT NOW?
Um, it can take a good 15 to 20 minutes or longer if I don't have the patient in front of me, doing it as I'm talking, interviewing the patient, unit for example, job title, I would have no idea. I don't know the MOS.

DO YOU TYPICALLY FILL OUT THE FORM IN FRONT OF THE PATIENT OR AFTER YOU DO THE INTAKE?
Half and half. If I'm covering the in-patient, I most likely would have the patient in front of me because it's easier. In the emergency room, frankly I never did because it takes me too much time already with the patients, you know, they want to get out of there.
The form is very complete, but it does take time to fill it out. I said 15 or 20 minutes, but actually I never timed myself. It depends on if I have all the information. Suppose the patient is not very

talkative, you can get all this information if the patient is talking, but then it's a different story. You have to find other sources.

IN ADDITION TO THE TIME IT TAKES YOU TO FILL OUT THIS FORM, WHAT OTHER RESOURCES ARE BEING USED IN PARTICIPATING IN THIS STUDY?

On the outpatient it will be even more difficult. Usually when I fill it out, I'm in-patient and where I fill it out I have been admitting the patient and give it to their secretary there [in in-patient psychiatry]. The personnel here in the Outpatient, the techs, they would not know how to send it, to whom to fax, or they don't have the forms on their computers. I need to ask a staff member from in-patient, and usually I give it to her because she knows the fax number and to fax and if there are questions to call me. Here I really don't have the capability. We demand a lot from our techs and they are very busy.

IS THERE A FORMAT THAT WOULD BE EASIER FOR YOU?

Something that they could do on-line. Even if it was just like fewer pages. Maybe the question would be 'what are you trying to track down with regards to suicides?' 'What is important for you, or whoever is doing the study, to know?' You may not know everything, but what are you going to do with all the information? You try to do more with less, and you try to be effective, so you don't want to get more work! It's just one more thing. When you interview a patient, it's a lot of paperwork and you can imagine where a new patient coming in has a lot of paperwork, so it's a lot of time. Time constraints – it's not that we don't like to do it, I like to do it. I like this, but the only thing is time constraints. This is what it [the data collection form] does, you sit down and focus. So I really like the idea, and that at least for now we can see what units are doing poorly. Is that because of the MOS, because of the GT score? So you have people with less coping skills for certain MOS, and that's why traditionally you would have more cases. Or is it traditionally that you had poor leadership? Or is it a very stressful, high-risk unit anyway? Who knows?

SO IN ADDITION TO HELPING YOU FOCUS YOUR FINAL THOUGHTS ON THE PATIENT, ARE THERE ANY OTHER BENFITS THAT YOU'VE EXPERIENCED FROM THIS STUDY OR FORM?

Sometimes, actually, more details about the event so then I know if it was on-post or off-post. I'm taking the history, so there are certain details that do help you. If you didn't have time during your admission because you had two or three admissions at the same time and so you kind of have to go a little faster and at the end you see if he was investigated by CID, or was the problem with the unit or family problems or seen by the chaplain. That's why I like to do this with the patient in front of me, because you can ask if they've seen the chaplain. Normally they tell you during the interview what's been happening for the past two or three months. Normally if they've seen the chaplain that will always come up for some reason.

[Interviewee is handed the newer form and given a brief background on it.]

Oh they have my favorite question! 'Did they communicate the intent to others.' I always worry about the ones that did not communicate the attempt. This paragraph here is not too clear, because you're asking about the victim's history, so you go into past history, then you go into – is it this event or some event that happened in the past. It has me confused; maybe it needs to be a little more clear. Or maybe it needs to be before the victim's history.

HOW DO YOU FEEL ABOUT THE NARRATIVE SECTION? This is new. In a way it's more complete. It gives you the full picture of why did you...Many times I write on this form anyway [*to clarify the answers given in the bubbles*]. You actually can just place two things – 'upset with wife' or

'angry at commander', 'wants to get out of the military', 'manipulative behavior.' It actually saves you time because on the other one you sometimes place some explanation.
SO DO YOU THINK THIS SECTION WILL HELP YOU CLARIFY THE BUBBLES?
Sure. It doesn't take that much longer, but it still takes time. They are all good questions, I guess. In the out patient, it's much more difficult. You really don't have the time. Even thought you have schedules, but you always have something else going on – there are telephone calls or other people come in, or the administration-wise, something comes up.
WHAT IS IT ABOUT IN-PATIENT THAT MAKES IT EASIER?
The patients are already there. The patients are going nowhere; you have more control. The patient who comes over here may go somewhere. I may not admit that patient; he comes on a crisis, you do crisis management. You may admit it, or not. Sometimes you do have the time to do that with the outpatient, it's not that we never have the time. There are crises that creep in on planned or spare time. So something like this that would take 20 or 30 minutes, because you have to read or don't have all the information – while on in-patient you do. You have their chart, that's very complete. In ours, our intake can be very complete, we have a section, but when you're on call, you have your patients so you need time to do your notes.

Interview # 4
Number of forms completed by interviewee: 9

WITH THE FORM AND YOUR EXPERIENCE, WHAT WOULD YOU SAY ARE SOME OF ITS STRENGTHS AND WEAKNESSES?
To start with, the time necessary to complete the form is always a hassle and particularly because almost all the time, the onus to fill out the form would fall onto the psychiatrist who was on call for emergencies. We are on call for a week at a time, so this could accumulate quite a number of self-injurious events that require reporting. Frankly, when I had to choose between filling out the form and taking care of the next patient, I would take care of the next patient and the forms would sit and they would accumulate, and I might get to them and I might not. Frankly when I was exhausted and sleep deprived, I really didn't care to go back and to fill out the accumulated forms. So, since we're going in for the honest version, looking over the months, I am sure there

are several times that I never did get back to the form – either forgot about it or was too embarrassed after several weeks and I just thought that I should just forget it – so it didn't get done. It got done sometimes.

AS FAR AS CONTENT, IS THERE ANYTHING THAT YOU THINK IS EXCESSIVE, AMBIGOUS?

I think the part that I had the most trouble with was the history of the use of helping services. There are quite a few bits in there that wouldn't necessarily come up in the course of an interview and unless I thought specifically to tailor the interview to fit the form, it wouldn't happen. More often than not when it came to the exceptional member family program, I simply hadn't thought to ask, and so it usually would be 'unknown' or once in a while it may coincidentally have come up. Financial counseling? I've never been in the habit of asking about that. And so on… A few like mental health or the chaplain, those would regularly come up, but often a lot of ambiguity or blanks on the form came from that. And under 'risk factors', stuff like psychiatric diagnosis there was some ambivalence because as far as I can determine on the form, it meant previously diagnosed established DSM-IV disorders. The more common situation would be that the person, from the history I was getting, may well have had such a disorder for many months but never had it diagnosed. Do I claim that he had a major depression three months ago, when the history clearly indicates it but a doctor never said so, or not? I usually err on the side to say if I think it was there, it was there, but still it wasn't crystal clear. Still, those are very relevant issues and good to have but you just need to know how to ask. Likewise with some of the life events, we generally get a pretty good handle on that but not necessarily in every emergency interview – as far as past criminal activity and legal problems. Obviously relevant but history tends to be incomplete.

It's relevant information but we wish we had the manpower to do it thoroughly and efficiently.

THAT MOVES INTO MY NEXT QUESTION ABOUT TAXING YOUR RESOURCES TO PARTICIPATE IN THIS?

It was seen as a reasonable thing to ask, but burdensome. Also it wasn't entirely clear how long the project would go on, in fact I'm not even sure – is it still running?

IT IS.

"In which case, I'm waiting on it."

HOW FEASIBLE IS IT THAT CONTINUING TO DO THIS IS GOING TO BE?

Well, it comes down to what results you really expect to get. In the present form it will continue to be incomplete and catch as catch can, so I would have my doubts about that unless something was done to make it less burdensome. One of which would be to remove the 24-hour deadline for reporting. During the emergency period on call is when you have the least administrative time available to complete the form. If you make it a week later you might get an even better response.

There again, one of the things that makes it more onerous is that quite a few patients make very minimal self-injurious acts, like fingernail scratches on the wrist where the same patient may do these things several times a week for months on end. It'd be a lot of forms if we strictly adhere to the criteria of any self-injurious acts. This becomes a running joke that we have another 7-page form to do. That doesn't mean that we don't do it – well, sometimes we don't – but we get to resent all the paper that's being sacrificed for the minimal and repetitive acts.

WERE YOU INFORMED AS TO THE REASONS BEHIND THE STUDY?
No, not really. Clearly somebody wants to study rates or qualities of self-injurious acts and I would hope it's with the intent that somehow we could better intervene or prevent such acts. Good luck!
I UNDERSTAND WHY YOU'RE SAYING THAT, BUT WHAT DO YOU MEAN BY 'GOOD LUCK'?
My experience to date has been that a great deal of fuss and bother has been put into so called suicide prevention with relatively little impact. People continue to get depressed because they are human, and people continue to consider and act out on self-injurious impulses. All the education in the world and all the administrative and institutional programs saying 'don't kill yourself' it's not going to stop them! So it's praiseworthy to say you can be treated at mental health before you hurt yourself – in fact I think one of the most productive things would be education to de-stigmatize mental health treatment because time and time again we have soldiers come in who have been suffering for a long time but were ashamed and embarrassed to consider themselves a psycho patient, so they just try to tough it out. A lot of harm and wasted suffering and dysfunction in their jobs could have been avoided if there was no stigma attached to early mental health intervention. That's where I'd like to see the investment.
HAVE YOU RUN ACROSS ANY SOLDIERS SAYING THAT THEY DIDN'T COME FOR HEALTH DUE TO FEAR OF RETRIBUTION?
"Oh yeah! 'I was afraid it would harm my career' is how the saying usually goes. It's usually among the more senior folks – the higher NCOs or officers – that fear a black mark on their career and denial of advancement, but on the younger soldiers, it's fear of ridicule from NCOs or their peers. In any case it's a very potent fear and keeps a lot of people away. It's true too.
HAVE YOU SEEN EVIDENCE OF THESE FEARS BECOMING REALITY, WHERE THEIR CAREER HAS ACTUALLY BEEN HURT?
I haven't followed anyone's career long enough to see this happen, but as far as ridicule, it is sadly very true, but it's not in any way limited to the military.
ANY SUGGESTIONS FOR COLLECTING THIS KIND OF DATA?
One of the solutions would be to hire a lot more doctors and pay them a lot more money and then we'll have more time to fill out the forms! It will only cost a few billion. It has some aspects of a noble effort, trying to learn the truth about things, but what are you going to learn? You'll learn what we've always known – that people get depressed about things and sometimes they feel like offing themselves. As far as really productive changes that will come from this, I'm dubious but hopeful. I hope this means that I won't be tracked down and prosecuted for failure to fill out the forms; it wasn't from ill intent, it was just exhaustion…
I ONLY HAVE ANOTHER QUESTIONS: WITH THE FORM, DO YOU SEE ANY STRENGTHS?
[*Interviewee looks through the new form.]*
It looks like it's condensed a little bit more. Narrative Summary! That will take even longer. If you really intend for this form to be filled out in a paper format, you'll have illegible handwriting in there, so you'd better put it on line. My own handwriting is awful and some doctors are worse. You don't want to get yourself into that space. The narrative summary allows you to get into more reality. I hope you know what you're getting yourself into. Somebody's going to have

to interpret all those mangled sentences, even if you could read them. That could be a great deal of work.

Interview # 5
Number of forms completed by interviewee: 15

HOW WAS YOUR EXPERIENCE WITH FILLING OUT THIS FORM? WHAT DO YOU THINK ITS STRENGTHS AND WEAKNESSES ARE? AND AT THE SAME TIME, DO YOU HAVE SUGGESTIONS FOR IMPROVEMENT?
On the front page, there's no problems with that, it's pretty easy stuff. The second page, one of the problems with this is the block on MACOMs of unit. We get a lot of other forces here besides the army. Are you interested in those people, and if so, how do we record it on here unless you want to put it in the "other" block. We get A LOT of folks who aren't in the army in here.
Duty environment isn't that difficult, sometimes it can be ambiguous. If they are in Grafenwöhr or Hohenfels, is that deployed or training? We can clarify that. Because it is kind of important if these people are doing this in the barracks or only in the field. It's certainly something worth looking at.
Then the 'use of military helping services,' I'm not really sure what to do with this, because does this mean that I need to go back and research every appointment that this person has had in the last year to see if he or family members have been involved in this? A lot of times this is kind of my best guess from taking the history – "Well he didn't talk about any financial problems, so I guess he didn't have any financial counseling" kind of thing. Some of it is no-brainers, but a lot of it is again my best guess. I didn't find these things to be very helpful.
Risk factors: This is really difficult. How they want us to clarify their psych history. Does that mean, when they were first diagnosed with it, when they were first involved in treatment? Like for a personality disorder, you have that your entire life, to say what does that mean – they were diagnosed within the last 3 months, they developed it within the last 3 months? It's kind of a useless piece of information. Psychotic disorders, or mood disorders – again, if they're depressed and it's clear from their history that this has been going on for a year, but it has only been diagnosed within the last 3 months, what do you want us to answer with respect to that?
SO FOR IMPROVEMENT IN THAT SECTION, YOU WOULD LIKE TO SEE US DO…? CLARIFY THAT WE SHOULD SPECIFIY ONSET VERSUS DIAGNOSIS?
Right, right, exactly.
And again, if known obviously, because that may be your best guess as well.
I think that was it. I don't find the form too tedious, it's really not that bad. It's just some of those things that we just talked about. It's just that when you're filling out the form and you got to some of those blocks, I didn't really know what to put there. Am I going to go back to the patient and asked if they saw EFMP within the past year? If I'm not that busy, I probably could do that, but to be honest with you, I never did that. It was all a best guess situation.

SO WILL YOUR WORKLOAD BE AFFECTED?
Definitely! And it is also just a matter of getting into the mindset of using it. This is something new to me; I didn't use it in my prior duty location. As a physician, we take a clinical history and this is not the typical form that we use. It's not a form that we're used to doing. It's a matter of getting into the mindset of "I know I'm going to see a patient who had a suicide attempt this morning. I need to remember to pull out that form and make sure I answer some of those questions?"
DO YOU THINK IT WILL BECOME HABIT? OR IS IT LIKELY TO BE A BURDEN?
It's just going to continue to be a burden. We'll do it because we have to do it. I guess it would be nice if we could see what it was being used for and if we knew that this was changing anything as opposed to just collecting a bunch of data. Are we using this data?
WHAT KIND OF FEEDBACK WOULD YOU LIKE TO SEE AND FIND MOST USEFUL?
Well, where is this data going besides just into some collection pool? Is somebody doing something with it? Are they going to apply it, or is it just for some study purposes? If this is just for somebody to write a research paper, I'd be very upset. I'm being used as a tool for somebody to do some research. If this is being used for some clinical outcome, to change clinical outcome, that's great. That's what I'm here for. It was never really clear to my why I'm doing this form. All anyone ever told me was "do this!" and I've never been told why and where the data is going. What are they using this for and under whose direction is this being done?
IF THE RESULTS CAME BACK AND IT RESULTED IN A CHANGE OF POLICY, WHAT WOULD BE THE BEST WAY TO LET YOU KNOW THAT THIS WAS A RESULT OF YOU FILLING OUT THESE FORMS? DO YOU WANT TO SEE A REPORT; DO YOU WANT IT TO BE E-MAILED TO YOU…?
Well, if they just sent us an e-mail that said, "Hey, you know all that paperwork you've been doing? We published a paper, and here are the results and here's how we're going to apply them in USAREUR, or army-wide. If you want to see the article, it's in this journal, or whatever."
The other question I have with this is what do we do with these folks who are constantly cutting on themselves? The self-mutilators. I honestly did not fill out a form on everyone who came in here who scratched their wrists. Maybe I should have because it's dangerous behavior, and that leads to further dangerous behavior, leads to suicide. Anyway, my fault, but do they want that? Do they want every self-mutilation? Because it's not a suicide attempt! Patient comes in and tells me "I didn't want to kill myself, I just wanted to relieve anxiety."
LET ME BRING IT BACK TO THE FORM FOR JUST A MINUTE, WERE THERE ANY POSITIVE PARTS OF THE FORM?
Although these things that I had to do my best guessing on, it did make me think 'hey that is interesting, all these things are out there and I wonder if they are making a difference.' It's not going to change much, but it makes me wonder… then it was also interesting if I knew that they HAD been involved in family advocacy and EFMP, I know they have seen an outpatient provider, they've seen mental health, they have financial counseling going on, and they're still trying to kill themselves. So what's going on here? There were a lot of patients like that. They are well-plugged into the system, they have all kinds of resources thrown at them and they are still trying to kill themselves. That doesn't affect your study but it gave me something to think about.

REGARDING YOU PARTICIPATION IN THIS STUDY, WHAT WERE SOME OF THE POSITIVE AND NEGATIVE ASPECTS OF PARTICIPATION FOR YOU SPECIFICALLY, AND ALSO THE CLINIC?

The negative things is the time, the ambiguous nature of some of the questions – it was frustrating to have to sort that out, and knowing that you had to put something there to move on, and then struggling with whether or not I had to fill one out for everyone who came in with a laceration. Those three things were the negatives.

The positives are that I think it's a fairly decent tool, there's a lot of good data. It made me think a little bit of all the other things that are out there.

THE NEXT ISSUE DEALS WITH FEASIBILITY. HOW TAPPED WERE THE CLINICS RESOURCES IN FILLING OUT THE FORM AND PARTICIPATING IN THE STUDY? I KNOW YOU SAID IT IS TIME CONSUMING…

It is time consuming, and again it just needs to be in the mindset, but I think if the form were streamlined and we were given additional guidance as to why we're doing this form, here's what we're doing so far. This is great, to see you guys here and so interested in the form, asking for my feedback and changing the form, that will make me think more – have it in my mind to do it.

WE WOULD LIKE YOUR FEEDBACK ON WHAT YOU SEE HERE [the revised form].

I have one very quick question – the narrative summary section, is that only for completions?

THAT'S NOT FROM US, BUT THE INSTRUCTIONS SAY IT IS ALSO FOR ATTEMPTS.

That's ridiculous! This is not going to get… I'd rather do this form! (Indicating the longer, "old" form). This is going to be frustrating! I am NOT going to write a narrative – well, I will if I'm told to – but it's unlikely that I'll have 100% compliance with filling out this form on every patient that comes in with a laceration that winds up being hospitalized.

The sequence of events? It's in the H&P; pull the charts if they want to know that! Ain't happening! I am NOT doing this.

LOOKING AT THAT, AND KNOWING WHAT YOU HAVE DONE IN THE PAST…

That will <u>DRAMATICALLY</u> increase our workload. Dramatically! I do not have the time to write a narrative summary on every patient that gets admitted that has a self-mutilation or a suicide attempt. It isn't happening!

WHAT ARE YOU DOING ALREADY THAT IS COMPARABLE TO THAT?

History and Physicals forms. So now I'm going to be doing duplicate H&P's on everyone. That's what we do here! I'm not going to duplicate my work. Give me a break, that's nuts! This IS confidential, isn't it?

ABSOLUTELY! NO NAME WILL BE ATTACHED TO YOUR COMMENTS…

This is not going to fly! What are other people saying?

YOU'RE THE FIRST PERSON WE'VE INTERVIEWED ABOUT IT.

I'll be interested to hear what leadership has to say about it! The bubble form is one thing, but….

LOOKING AT THE TWO-PAGE BUBBLE STUFF, WHAT ARE YOUR THOUGHTS ON THAT, BECAUSE IT IS SCALED DOWN FROM WHAT WE HAD PREVIOUSLY? *[Interviewee looks closely at the form, reading various parts out loud.]*

So this is saying that I'm supposed to review <u>all</u> medical and mental health records of the patient. (Reading) 'Interview all co-workers and supervisors of the patient.' Now we do that a little bit

Appendix H – Transcripts of Clinical Provider Interviews cont.

here, but to tell you to review all the medical and mental health records – again that's all that's available, so if they're not right there in front of me, they're not available. Am I supposed to go seek out their medical records and their convenience file over in Würzburg, and review that? No, that's not going to happen! And how far back? For suicide completions, that's different.
I'm not sure what the purpose of this is, why they're linking this into the suicide completions. I don't understand that. In decreasing the work for a suicide completion, you're dramatically increasing the work for a suicide attempt, where you have very few completions and numerous attempts! It swung the pendulum the other way.
If this has to be done, it's going to be like: 'patient depressed, cut himself.' 'Patient with borderline personality disorder.' That's it!
COMPATING THE TWO FORMS, HOW MUCH MORE TIME DO YOU THINK IT WILL TAKE TO COMPLETE THE SECOND (NEW) ONE?
Over 100% longer! This could take a half-hour, easily, or longer. It takes 10 minutes to do the old one. This is NOT going to work! (Reading) 'Risk management analysis' – whew! Pardon me if my affect is showing! I don't need all this extra work! That's ridiculous! That is NOT going to fly!
The hardest part of this was remembering to do it. It's an easy form to fill out. The problems I had was, again, with the questions I already mentioned – where do they want me, when are they talking about, diagnosis versus time of onset, that kind of stuff, struggling with what unit they're in. It's very easy to put 'unknown' – I try to put something that's right.
IS THERE AND EASIER FORMAT THAT YOU'D LIKE TO HAVE THE FORM GIVEN TO YOU IN? DO YOU PREFER IT ELECTRONICALLY, OR…
I have it on my computer, I just print it out. I would probably rather have it in this form (indicating paper) than to have it on the computer to tell you the truth. It's tedious to click around. I'm not one of those people who is totally automated. I still like some paper forms.
WOULD IT BE MORE PRACTICAL IF THEY TOLD YOU TO ONLY FILL OUT THE NARRATIVE ON COMPLETIONS?
Oh yeah! Because I don't see completions. Someone is assigned to do it. I know they're doing away with the Psych autopsies, and all that. I think this form could be usable for serious suicide attempts, but that all comes into clinicians' judgment and all that stuff. I think serious suicide attempts probably warrant further evaluation.
HOW WOULD YOU DEFINE A SERIOUS ATTEMPT?
Well, that's the question. It's not self-mutilation. Intent, the means, the plan – was there a rescue plan in place or not, was the person likely to be successful if they were not found. The stories are all very distorted by the time they get here. It's something that's very ambiguous at best. I don't know what the answer is, but this is not going to fly for every self-mutilation that comes into the hospital. We see too many of them – it's over 50% of our admissions probably. That's why we're here! We're an inpatient ward. The vast majority that come in here are personality disorders – vast majority. They all have some self-mutilation history. Is it a serious suicide attempt if someone puts a loaded gun to their head? Are we going to fill out forms for that? I could go on for days!

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THERE'S A SECTION THAT WAS ADDED, IT'S NOT IN THE CURRENT FORM, AND IT'S ASKING ABOUT VICTIMS HISTORY. I'M CURIOUS WHAT YOU THINK OF IT. GOOD, NOT GOOD?
All very good questions, take out this 'explain' section in part 2b. Anything that involves writing is bad. Bubbles are better! When you're doing large studies like this, it's much easier to condense because someone has to read all of this and put it into some kind of computer program. It comes down to: history of abuse or not, history of substance abuse or not, history of mood disorders. Whether or not I write out that the patient had a history of sexual abuse as a child, or I check a block – what is the point of that? Everything that I write out here (in the narrative section) is just going to be a consolidation of all the stuff that I've just clicked off on. I think this is redundant, overkill, whatever you want to call it. This form is not going to be accepted very well.
Wow! I'll be happy to continue filling out this (indicating the 'old' form) form until I receive order to start with the new one. I haven't received any orders yet, as far as I know.

Interview # 6
Number of forms completed by interviewee: 8
(THIS INTERVIEW WAS CONDUCTED BY TELEPHONE, NOT TAPE RECORED, THUS THIS IS A SUMMARY OF THE INTERVIEW, RATHER THAN A VERBATIM TRANSCRIPT)

Form
Weaknesses of the form:
- The current form is not set up for easy electronic completion; it's too cumbersome.
- What is ethnic group none and other? Also, where is one for Caucasian/White?
- Race is too specific.
- MACOM could be shorter, don't see the majority of those listed.
- Helping Services – provider does not have time and isn't going to contact the different agencies
- Risk Factors – provider is not going to know most of these and again, does not have time and isn't going to seek out the information
- Information for the form is taken from the intake interview with the patient.
- Form not helpful.

Strengths of the form:
- Benefit is EUCOM sees what's happening in this location.
- "Doing form to let general staff know how shitty it is down here"

Participation in Study
Drawbacks:
- "I'm a zombie doing admin work requirements," the form is one of many.
- Provider is swamped with duties to fill out admin forms; too much paperwork is an administrative burden.

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Provider is only credentialed provider in this location with access suicide and homicidal patients. Another credentialed provider is needed in this location.

Feasibility

Provider is overstressed. Provider was told that he knew going to this location what it is like; provider said, "that excuse only goes so far"
Provider works 60+ hours per week.
Agencies in this location are overworked, understaffed. In 9 months FAP cases have increased 50%.
This location is a small post, has a high OPTEMPO; new unites are moving in, politics and work [mental health clinic] are awful.
This location is an overpopulated post, under a lot of stress, and has high drinking levels.
"We will have a suicide attempt here"
"Everyone is apathetic about healthcare needs until somebody dies"
Acuity level has gone up; seeing stranger cases of pedophiles, homosexuality, etc.
The Army is "squeezing me dry"
Italian psychiatric health care system is not set up to deescalate violent, confrontational patients – providers working on training them with these skills.
High psychiatric admissions in this location: 25 in 2001 and projecting 40 in 2002.
Command in this location do not support mental health clinic; just wants provider to see patients and keep quite. Against provider's recommendation, a patient was given all his medication while on one-to-one suicide watch, instead of just what he needed, and the patient overdosed.
Provider has to complain a lot to get what he wants.
Provider will complete his contract obligation with the Army and then he's leaving. "The system is broke for healthcare and it's going to get worse."

New Form

"The narrative has made it really tough"
The narrative will take extra time to fill out.
"Providers are going to breeze through the questions"

Interview # 7
Number of forms completed by interviewee: 2
(THIS INTERVIEW WAS CONDUCTED BY TELEPHONE, NOT TAPE RECORED, THUS THIS IS A SUMMARY OF THE INTERVIEW, RATHER THAN A VERBATIM TRANSCRIPT)

WHAT DO YOU THINK ABOUT THE FORM? ITS STRENGTHS, WEAKNESSES?
"It's filled out by one person in the clinic, and if I'm not aware that something has happened, then it doesn't get filled out." He used to rely on a backup person to let him know if there was an attempt for which he had to complete the form, but she has PCSed and he doesn't have a replacement for her. He also tried to rely on the patient liaison, but they didn't have the time to keep him in the loop either. He suggested that if the patient's doctor could fill it out it would be

Appendix H – Transcripts of Clinical Provider Interviews cont.

best, but he also pointed out that not everyone that comes to his clinic belongs to his community. This also brought him to the problem of records that are maintained in other communities. He tries to get them in order to complete the form, but isn't always successful.
The form itself: Photocopies: The shading causes poor photocopy reproductions, so the headings become hard to read. Some blocks don't work for anyone who is not a soldier – namely children and dependents. The duty status section doesn't say "dependent" or "civilian" so he was confused about whose information to fill out. Victim's Intent: In his case, he doesn't always see the patient before he or she is transferred to hospital, so this information is second hand from the patient liaison. Military Helping Services: "This is harder to find out unless I talk to a family member." Oftentimes psychiatry appointments are not kept in medical records, so he doesn't know about those appointments without speaking to family members. His clinic maintains a good relationship with the chaplains services, so that section is often more accurate. He also calls the patient's unit to determine what other services they may have used. Initial Disposition section: He finds this section particularly difficult because most patients get transferred to LRMC. "No loop is closed. The information never gets back to me unless I was tracking the information closely." He doesn't know if a patient he sends there is admitted or even seen.
IT SOUNDS LIKE YOU ARE VERY INVOLVED IN FILLING OUT THE FORM. DOES IT TAKE MUCH TIME FOR YOU?
He said it takes about 30 minutes to fill out each form including phone calls to units, chaplains and records clerks.
WHAT ARE THE STRENGTHS OF THE FORM?
It is an "easy form to work through." He liked the check boxes and found the form to be well written and easy to follow. When asked particularly about the risk factor section, he reported having no particular difficulty with the section because he understood what the question was trying to get at. He said the vast majority of these cases that he sees have a combination of marital and financial problems and rarely have other factors/disorders complicating it.
WHAT ARE SOME OF THE DRAWBACKS OF PARTICIPATION IN THIS PROGRAM?
There are no additional problems aside from the few that he mentioned. He had no problems with faxing the form because it enabled him to scribble in the margins and he also appreciated being called back when there were questions. "It's good to be the point of contact, but making sure about all the follow up is not so easy. He suggested that perhaps LRMC could fax him a courtesy copy if it were a patient he sent there so that he might know if they were admitted.
Feedback: "Is anybody even looking at this stuff? Does anybody even care if I forgot about one patient?" He wanted to know the point of the data collection and if it was being used for improvements. He wants a cause and effect relationship to know if the suicide prevention training given to units twice a year is having an effect and also some results that tell him if there was anything that could have been done to prevent a suicide.
HOW ARE YOUR AND THE CLINICS' RESOURCES BEING AFFECTED IN ORDER TO PARTICIPATE IN THE STUDY?
Time: It doesn't take much time to fill it out, but it's still something that they don't have much of.
Reproduction: There is minimal cost associated with photocopying the form, but he would still appreciate it if he were sent a packet of preprinted forms.

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Submission: He would REALLY like it if the form were on-line at a website where he could just enter the information that way rather than by hand & fax.

Interview # 8
Number of forms completed by interviewee: 32

I WOULD LIKE TO KNOW YOUR THOUGHTS ON THE FORM IN GENERAL – ITS STRENGTHS, THE WEAKNESSES, THE CONTENT, LAYOUT.
The thing that I would say about it is and the number one feedback is that, it is really hard with the clinical pace that we keep up here to keep up with these forms. And this form [*current 7 page form*], as I see it, probably takes less time to complete than that form [*newer 2 page form*]. And even though that form looks like it has fewer pages it looks like to me is that it really comes down to the fact that it's a much more crowded form and it actually appears to ask for more information not less. So it's kind of like that everything from the seven pages has been crammed in here.
I think that . . . and then of course, then there is also the concept of these narratives as well. Even with our history and physicals the pace is such that a lot of this is check off [*Interviewee shows interviewer the forms the unit uses from a patient's chart*] and a lot of it is preprinted, we need to know exactly these things and not other things. I think in terms of giving you food for thought, I think that the kinds of things that it would take to make this work in terms of reasonably reporting it contemporaneously, like as things happen, as opposed to you having to come in at the end of the quarter, is somebody local can come in and do this [*the investigation form*]. Even in talking with the guys at Walter Reed Institute of Research is this has been instrumental that they've got to provide somebody that's going to be on site to collect this data because we are just going at times and you know on a day like today we might or might not get it done. But this is not the busiest day by any means and things like this interruption you just had can turn into a three hour consumption of time very easy for us. So being able to consistently record the data is something that I don't see as being very likely to happen. Partly because of the clinical caseload but also partly because of the inherent chaos of Inpatient Psychiatry. So again in terms of if you want data collected here you are probably going to have to have somebody come in regularly to do that. We can redesign our forms so we go through things that we can record better but I think that again that rather than us filling out additional forms that the reality is going to be that the researchers are going to have to use existing forms to collect the data from and in a way their desire to know may be much greater than clinically we can sit down and collect the data. Much of the data is either already captured and for example, in terms of gender, the date of birth, all these things exists already on the thing or the other . . . like in this form here, the business of communicated intent to – that sounds like a simple question but it actually takes a fair amount of questioning of somebody to come up with idea that "did you ever tell anybody" you know. In terms of what is important clinically in terms of understanding what happen, we wouldn't get into that sort of detail. I usually sketch out what the person did in the hours before and what did they do after and some of that is to just understand kind of what was going on in their head and how likely are they going to be safe in a short period of time. If somebody

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planned for a month to kill themselves that's different than somebody who got a call from CONUS and said you know, "hey, I'm sleeping with a whole battalion" and took a dose of pills right there on the telephone and then said oops I made a mistake and I've got to tell my CQ desk. Those are different situations and how they are managed on the ward will be different. Again in terms of the amount of information that is desired on this thing seems like too much for us to collect and a lot of it is not clinical data.

THE ONE THAT YOU'RE LOOKING AT [*7 PAGE FORM*], THE HELPING SERVICES, HOW FEASIBLE IS IT FOR YOU TO GET THAT INFORMATION?

Absolutely, non-feasible. You already may have heard that. We may be aware of medical treatment but one of the things that is a reasonably well documented thing is that. This again is something like, why would be looking at that issue again? Is that what we are looking at or are we aware of what the literature already says in these areas? And if we are looking at that then maybe what we need is a sub-study that looks at these things rather than tries to include that in a study about suicidality. Once you identify these people it would not be hard in Heidelberg's CHCS and look at how many clinic visits these people have had before and sort that out but for us to take the time to sit down and to figure out how many visits that they have had its just not feasible. I have many days where I don't write progress notes on my patients because I do not get to it because there is so many things coming up so the idea that I am going to be able to sit down and look up on a consistent basis people's prior health visits and some of these other things as well, we may or may not know about but we may not have anywhere near the detail of information. Some of these things are not easily discoverable clinically like financial counseling. We make our unit contact and again one of the things that is conceivable in the unit contacts by the social worker is maybe they could do a form. This is again is something that may fit in with them is to what kind of problems that they have had. It is something where if it is a task that seems beyond what we can reasonably do on a consistent basis clinically. Things like the previous non-fatal self-injurious events, mood disorders, personality disorders these are relatively straightforward things that we can put down. That shouldn't be a problem with putting down; however, again in terms of looking at the redundancy issue is that these are factors that we routinely record on the history and physical and where if there was someone who came and looked at the history and physical, looked at the charts, they would be able to pick that up and score it pretty easily, but for us to get into another form. I think the history that everybody sees is we haven't done it consistently. We can take the oath to be better people but it's probably not going to work.

ON THAT SPECIFIC PAGE DID YOU HAVE ANY PROBLEM WITH THE AMIBUITY OF THE QUESTIONS OR THE TIME FRAME OR ALONG THOSE LINES

Its always ambiguous in terms of timing because again trying to get patients to commit to when did something happen, even the issue when did a suicide attempt happen, its like (talking as another party) 'well I think it was Thursday night, maybe it was Friday morning, oh, I don't know, I was unconscious for two days after that so I am not sure when it was.' Even something like that, but when you talk about did it happen exactly in the last three months or not, that's again one of those measurement things where you're probably not going to get a real good answer on that. I hope that's a helpful answer. Just about everything gets to be…Just the sheer number of these questions about the military legal problems under investigation or apprehension,

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those are ratable things, those are things that we probably capture in the course of our history's in the social workers contacts but in terms of whether we will be able to capture that and transfer it to the form it just seems much more reasonable to me that somebody, that a research assistant comes in and does that. My suspicion is that probably there are people in the community that can be higher, people we routinely have nurses that volunteer so you could even get RNs. You could do more complicated things in terms of rating people but you just need to have somebody on site that's going to see it as their job to do it. I wish we were better people and doing it. I certainly believe in research but the clinical issues, in terms of having the time to do it or something.

YOU'VE GIVEN US A REALLY GOOD PICTURE OF WHAT THE FORM HAS, AND WHAT THE DIFFICULTIES OF THE FORM HAVE BEEN AND TO FILL IT OUT. HAVE YOU SEEN ANY STRENGTHS WITH IT HELPING WITH TREATMENT CARE OR JUST STRENGTHS IN GENERAL LOOKING AT SUCICIDE

No. The things that were helpful... It was helpful to me mostly was the briefing topic when you came and did the study where you figured out how many suicide attempts we had in the last year. I think again that it is a reasonable thing for us to know about and I do use that when I talk to commanders. I say, hey we see seven hundred people here a year, most of them have suicide ideation and two hundred of them have actually made suicide attempts, so it is not like this is the first time this has happened. But in the terms of, is that form giving us anything, probably not. The other thing is that the way the data collection is organized is that it fell to us as the last person in the chain to be the ones to fill this out and it may well be that the people in the out-patient clinics who are probably the first people in the chain might be the ones that might be able to do it. As I see it, one of the things that happens is the more portals of entry, the more questions about whether the data is collected or not and then with the fewer portals then the issue is that it may just not be doable in terms of our getting the job done. I think again that a great deal of the data is there and at least what I would say that probably might be a bit more expensive but it might be more reliably done is the idea of having somebody that comes in periodically and looks at the charts and gathers this data, they could go down to medical records and look at the people that were discharged last week and look at their charts and gather..... And that way at least there kind of not the redundancy factor. We have put this down as one of the things that we capture on, trying to find the telephone intake, that's one of the things that is on the phone intake, you have probably seen that in the course of the year. And that is also on, had been, even before the study had began, had been on this thing here. One of the issues even in the course of usual events, is that somebody could come in to us from a deployment in Kosovo, they made a suicide attempt in Kosovo, they come here and their follow up care is in hospital, and if we do not let them know that then they might not be even aware of there was a suicide attempt. So it's included both on exit and on entry. Now we have control over what we fill out in terms of our routine stuff. The telephone intake sheet is usually filled out by the nurses and captures data there. That's something we did to try to make sure that we capture these things. I imagine anything more that I would say would probably be redundant. What other kinds of issues do you have?

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HOW YOUR RESOURCES HAVE BEEN AFFECTED IN ORDER TO PARTICIPATE? WHAT ABOUT THE UNIT, ON YOU WORKING WITH PATIENTS, PATIENT CARE AND HAVING TO FILL THESE FORMS OUT?

Patient Care comes first and all paperwork comes after that. Some paperwork is paperwork, if I don't fill it out the patient doesn't get discharged. If I don't fill it out, the patient doesn't get out of the army, o.k. for better or worse this is paper work. If I don't fill it out then research people are unhappy at me who are not even in the same building as me. You can see that it falls down in terms of the overall priority. Again, those kind of interruptions that come, come periodically. And if you are trying to fill out a seven page form or a two page form that has seven pages worth of information on it then you may just not get back to it. I had one of these forms that laid on my desk for about three months and it was exactly half done where I had started and something else had come up and I just never got to it. This desk is relatively clean at this point and you may have seen it in the past, anyway. This is relatively low in terms of the pile that has accumulated here. Again, the patients are going to keep coming and we are going to need to keep doing what do for the patients and the reality with any research project whether it is about sleep or whatever is going to have to occur in a very busy ward and its one where the clinical people, I don't think, really have the time to do these things. We can promise to do it we can be threatened and be told to do it, but the reality is that we're going to end up not getting it done, because we just have too much else to do. We have at this point. In 1994, when this ward opened we had, compared to then, we now have fifty percent of the overall staff because of the various ways that the army comes up with staffing patterns. And we have, at this point, 1.3 times as many patients coming through here. So it's a 30% increase over what we did in 1994, but with 50% less staff. Again, that gives you some idea. We have right at this moment 7 RN's, one of whom is the head nurse who can do no clinical work, so we got 6 RN's to cover 24 hours a day, seven days a week, every day. Again, we have something like in the vicinity of nine techs, in 1994 we had eighteen.

HOW WOULD YOU ESTIMATE IF YOUR PAPERWORK LOAD HAS INCREASED OR DECREASED IN THAT SAME TIME FRAME?

It has increased dramatically in the last year for the nurses primarily because with JHACO coming now there are new forms for everything. So again, in terms of what I am hearing from the nurses is that their patient care versus paper work division of labor. Their patient care part of that has been shrinking already because of paperwork that they have to do. If we go through this chart here probably a quarter of the thickness of that has been added in the last probably year to eighteen months because technically it has to be around for a year for JHACO will believe that it is paperwork. There are quite a number of forms that just showed up in the last year or so. One of the things might be, could anybody else do it, could the techs do it, there is not enough techs. We often times have had to book an extra RN to work because we didn't have enough techs, we had one tech whereas we needed two or three in the ward. Now with only six floor nurses, we can't book extra nurses to fill in for the techs and our minimum staffing here is different than the minimum staffing on the med floors. As a psych unit we need a minimum of three RN's on the floor. There's not really any body else that is going to be available to do that. The social workers already have the most consistent over time, compensatory time in the hospital so there is just not anybody else that can do things. So again, my opinion on this is that there needs to be

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someone else, some kind of person that could that could come and collect the data on a regular basis. WITH THAT IN MIND, WITH THE NEW FORM THIS IS A ARMY WIDE SYSTEM NOW. WHAT ARE YOUR THOUGHTS OF THIS ARMY WIDE THING COMING UP AND HOW IT'S GOING TO AFFECT YOU?
Oh sure, it's going to be the same issues. The difficulties are there no matter who is collecting the information and it's going to depend on how much they want the information collected. Because certainly we can't do it here, not with 700 people, 200 suicide attempts in a years time. Getting 200 forms doesn't sound like much in isolation but getting it while you're doing 700 patients . . . Psychiatric mental health productivity looks low compared to other people. In civilian practice, an internist can, in a busy clinic, see people about every 15 minutes. So they might in a days time if they work 10 hour days see about 40 people. Some people push that. When we look at psychiatry, I may see 5-6 people, but the amount of face to face contact is probably more than the internist but the amount of peripheral issues is a great deal more. There are no lab tests to figure things out. Just like with the nurses, they have to spend more time with the patients than they would if they were at an internist's office. The numbers here are fairly overwhelming. To give you an idea, we do as much as Fort Hood and Fort Bliss combined, those are about 350 admissions per year. Eisenhower is about 350 admissions. We do 700. I don't know how that compares to Walter Reed but they have 35 beds. We have 18 beds. There's quite a high turn over here.
DID YOU HAVE ANY SPECIFIC IMPRESSIONS OF THE NEW FORM?
It's fewer pages but it's not any less information. In fact there's probably more information required with this narrative things. Whoever would like to have this information collected is going to have to get somebody to come here to do it if they want it collected on an ongoing basis. Even if they're screaming at us loud and strong, I think the reality is going to be the same. There are going to be months at a time that we're not going to get to it. Then maybe a day or two or week here we can get to it. It's going to be the same issues.
ON THE NARRATIVE PART, DO YOU FEEL IT'S MORE JUSTIFIED THAN OTHERS TO COMPLETE THAT SECTION?
It's again something, we already produce those records and why aren't those records be adequate? The issue is, the information is probably already there. The information is recorded clinically. This is largely redundant or it involves getting in to areas that we don't have information about. We'd have to spend additional time interviewing patients.

Interview #9
Number of forms completed by interviewee: 6

WHAT ARE YOUR GENERAL COMMENTS ABOUT THE CURRENT FORM?
In general, the from is fairly easy to fill out. There were some minor glitches on the original form and I think those have been located and taken care of. I need to be honest, for example when they talk about the use of military helping services, some of these items we have the information and some of these we simply do not have the information. Typically if we're interviewing

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someone in crisis – which is after a suicide gesture - we rarely go into whether or not they've been in touch with child and youth development. I just need to be realistic about that, and so in those cases we will mark 'unknown'.
The rest seems pretty easy as a diagnoser. When you have medical and mental health records, personality disorder, by definition is a chronic thing, so even if it's first formally diagnosed in the past three months, by definition it HAS to have been there since early adulthood or late adolescence. But otherwise, I don't have any significant problems with the form.
As a clinician, I'm wondering what the point is in trying to include self-mutilating behavior within a suicide study simply because clinically those two are very distinct events with different backgrounds and different outcomes. And, again one of the comments that most of us have made is that for many of our patients smoking and drinking are far more harmful behaviors than scratching their wrists. But we report the wrist scratching and we don't report the alcohol and other substance abuse.
ARE THERE ANY PARTICULAR WEAKNESS THAT YOU SEE FOR THE FORM IN PARTICULAR?
No, not really. We all grouse about 7-page forms, but frankly it doesn't take long to fill it out.
ANY STRENGHTS?
It is fairly straightforward and fairly simple. I think in that sense, for the amount of information that it attempts to gather it's a good form.
WOULD YOU RECOMMEND ANY IMPROVEMENTS TO IT?
I guess the only thing, is that when you have a form that covers so many areas, obviously there are going to be some that are not readily available. We'd have to be interviewing patients, thinking specifically of the form, rather than trying to make a clinical decision. I don't think that's a very wise thing, and really its not very practical. Again, we're taking about patients that sometimes we see at 0-dark-hundred in the emergency room, or on a very busy clinic day when we know that every extra minute we take with this patient means more to those out in the waiting room will have to wait. So, obviously the simpler the form is, the more likely you are to get accurate information.
HOW HAS PARTICIPATION BEEN AS FAR AS CLINIC RESOURCES?
As far as taxing the system? Paperwork is always a problem. I think all of us feel that we spend far more time filling out papers than we should because it means less time that we have to be with patients. I think most of us feel that face-to-face interaction with patients is what we do best. It's what we're good at. Realistically, the form doesn't take much time to fill out. I am painfully aware in my own experience that there have been patients that I have seen and may have thought about filling out the form and haven't done it. It's just slipped my mind and I suspect that happens to some of the other clinicians. We've made a point of – whenever someone presents a case that meets criteria for the form in morning report – to remind the provider it needs to be done. I'm not sure the compliance has been 100%.
ARE THERE ANY OTHER ISSUES?
Not really. A matter of faxing is not generally a big problem. I don't think there are any other major issues.

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HAVE YOU RECEIVED THE NEW FORM, THE ONE WITH THE NARRATIVE ON IT? WHAT ARE YOUR THOUGHTS ON THIS FORM IN LIGHT OF YOU PARTICIPATION AND JUST LOOKING AT IT AS A CLINICIAN?
I think that the most noticeable difference is that this form is for many, many less cases than what is covered by the other form. This is limited to suicide attempts requiring hospitalization or completed suicides, which is many, many less than the suicide attempts that we see here in the clinic where there has been wrist cutting or overdoses but didn't require hospitalization or didn't seem to need it. So in that sense – but anything that does require a narrative is going to be more work, and in that sense I think the participation – something that requires a thoughtful answer – I think there will be varying response from clinicians. I think some will give some very helpful information and others will not do so.
DO YOU HAVE RECOMMENDATIONS FOR THIS PROJECT?
The new form? We've not used it yet, we're waiting from work from ERMC, so I have glanced at the form but have not attempted to make any analysis of it.
WE'RE MOVING INTO SOMETHING ARMY-WIDE. WHAT ARE YOUR THOUGHTS AND FEELINGS ABOUT THAT?
I'm aware that the army's study of completed suicides has been very sketchy because many of the psych autopsies never make it up to the big database and hence the information is incomplete. It probably remains to be seen if this new method is going to garner better data. I think all of us find data profitable – being aware of what's going on in the military. This area is useful to all of us – in identifying some weaknesses in what we were doing.
PERHAPS IT WOULD BE MORE HELPFUL TO THE SYSTEM IF WE WEREN'T JUST TAXING IT TO COLLECT INFORMATION, BUT RATHER THAT WE CAN IMPLEMENT SOMETHING OUT OF ALL THIS WORK THAT'S BEING DONE.
Oh absolutely. I think that, in turn, motivates clinicians who can use the data to do things differently. It think that's really where the money lies.
ON THE NEW FORM, IT ALSO ASKS FOR ATTMPTS SERIOUS ENOUGH TO BE ADMITTED INTO TREATMENT. DO YOU SEE THAT AS A BENEFIT TO BE TRACING SUICIDE ATTEMPTS IN THE ARMY IN GENERAL, AS OPPOSED TO JUST DOING PSYCH AUTOPSIES?
Well, everybody agrees that suicide attempts are a hazy field. There's even disagreement in the field about whether we should differentiate between suicide gestures and attempts, except clearly some people do make attempts that are genuine and don't succeed. Others, fairly clearly, are trying to manipulate the system by what they do, but it is always a judgment call. In that sense, I think specifying 'these are suicide attempts which require hospitalization' at least suggests that there was enough seriousness to the attempt that there were some real concerns about the patients safety or viability that I think makes them not certainly cover all the attempts, but will give us a firmer database to try to address that particular area that I think has not been particularly well addressed in the suicide literature.

Appendix H – Transcripts of Clinical Provider Interviews cont.

Interview #10
Number of forms completed by interviewee: 1

I WOULD LIKE TO KNOW YOUR THOUGHTS ON THE WEAKNESSES, SOME DRAWBACKS TO THE CONTENT, LAYOUT, JUST THE FORM IN GENERAL.
I have a lot of thoughts about it. First of all, when you have a number of only 5 to 6 per year it's very hard to come up with meaningful data. I believe the Army wide figure for suicide is 70 for last year but here in Europe there were only 5 or 6. When you're trying to pin point some . . . whatever it is you're looking for, it's very difficult when you have an "n" that's so small. With that said, this primarily just a very superficial data gathering form that doesn't tell a whole lot. Even if you found a cluster, I don't think this would tell you much. The main thing that this form does not address is the person's background. Most of the difficulties that people have are not unique to their time in the Army. Their troubles they had were long before they met the Army and they are troubles they'll have a long time after they leave the Army. From this form, you can't really identify those. There are a few things here like . . . they are wanting to know if drugs were used during the event and was alcohol used during the event and if in fact were substance abuse services used a month or 12 months before the event. That really doesn't address the real issue about personality disorder and so forth and that is the main issue behind suicide attempts. I don't know that this form is going to help a lot with identifying the real issues. That's what I've said before and that's what I still think.
SOME THOUGHTS OF IMPROVEMENT: IF WE HAVE TO REVAMP THE FORM, WHAT WOULD BE YOUR FEEDBACK?
I would do a lot of thinking about what it is we're looking for and I think that is true of any research study. You do most of the work in your head a long time before you take paper and pencil and start devising things. You may mess about for a while about what is it that I want to see, what do I want to find. I would do a whole lot of thinking about it. Then see if there is a reasonable way that one can determine any of these things. I don't believe this form is it. I think it will be a lot of man hours and money expended for very little or any return. It may satisfy a political issue because somebody wants it. In terms of science, I don't think so.
DO YOU SEE ANY STRENGTHS OF THE FORM? ANY POSITIVES?
I think it is kind of a standard demographic form. I don't think there are any strengths or weaknesses in particular. It's just kind of a standard demographic form.
WHAT ABOUT WITH PATIENT CARE? HAD IT BEEN EFFECTIVE?
No. I don't know that it is meant to be effective for patient care. I can't conceive of how anyone would see this is having to do with patient care, it's not. In fact it probably detracts more from patient care than adding anything positive to it.
HOW SO?
It's more forms the doctors have to fill out instead they could be doing something else than filling out this form. In no way does this contribute to patient care.
IN REGARDS TO PARTICIPATION, WHAT HAVE BEEN THE DRAWBACKS ABOUT PARTICIPATING?
Not much for us here. I think we've only filled out one here in the past year and a half, since it started. We set it up so that this would be completed at the highest level of care the patient

would receive. Otherwise we'll end up with many duplicates. Most active duty persons that we see who have attempted suicide, we send them to Landstuhl to be hospitalized. If only to expedite their discharge from the military, even if they're not mentally ill. So it's a very rare active duty case that we see that we send them home or back to duty or whatever without being hospitalized. I believe that there was only one that was an active duty person who had made some sort of impulsive gesture and then seemed to be fine and was taken to a German hospital. That is very unusual because most of them go to Landstuhl.

LOOKING AT THIS GLOBALLY, ARMY PSYCHIATRY, WHAT ARE YOUR THOUGHTS ABOUT PARTICIPATING IN A STUDY LIKE THIS AND THIS STUDY WON'T BE THAT MUCH DIFFERENT FROM THE SURVEILLENCE SYSTEM THAT WILL BE IN PLACE.

I think that study (surveillance) may be more beneficial than this one is.

HOW SO?

Well, because you're going to have a larger "n." It's going to be world wide. You're going to be looking at the material in a secure website at AFIP. AFIP is then going to do worldwide statistics. That may be more productive.

AS FAR AS FEASIBLITY OF FILLING OUT THESE FORMS, DO YOU SEE PEOPLE PARTICIPATING WITH ALL THE OTHER WORK PLACE DEMANDS?

I think people will do it if they feel there is a value to it. I think physicians, if they think that something is productive, will turn to and get it done. If on the other hand they view it is as nonsensical paperwork, probably not.

WHAT DO YOU THINK WOULD PUT VALUE TO IT?

To be able to get feedback for one thing. That's been my thing with this. To my knowledge there have no results distributed of this. If you want the people to do this and support them and take it seriously you're going to have to show people this is what we've found. That's the basic tenets of science. You don't do something and hide it under a barrel and frankly that's what's happened here. Everyone is saying, what has been done. If you expect people to do this and fill it out, then you're going to have to share with them what's been found so they feel that they're doing something productive. The one that [leader] is doing will be shared and people will be able to look at that and see exactly what the issues are worldwide and the "n" won't be 5 or 6.

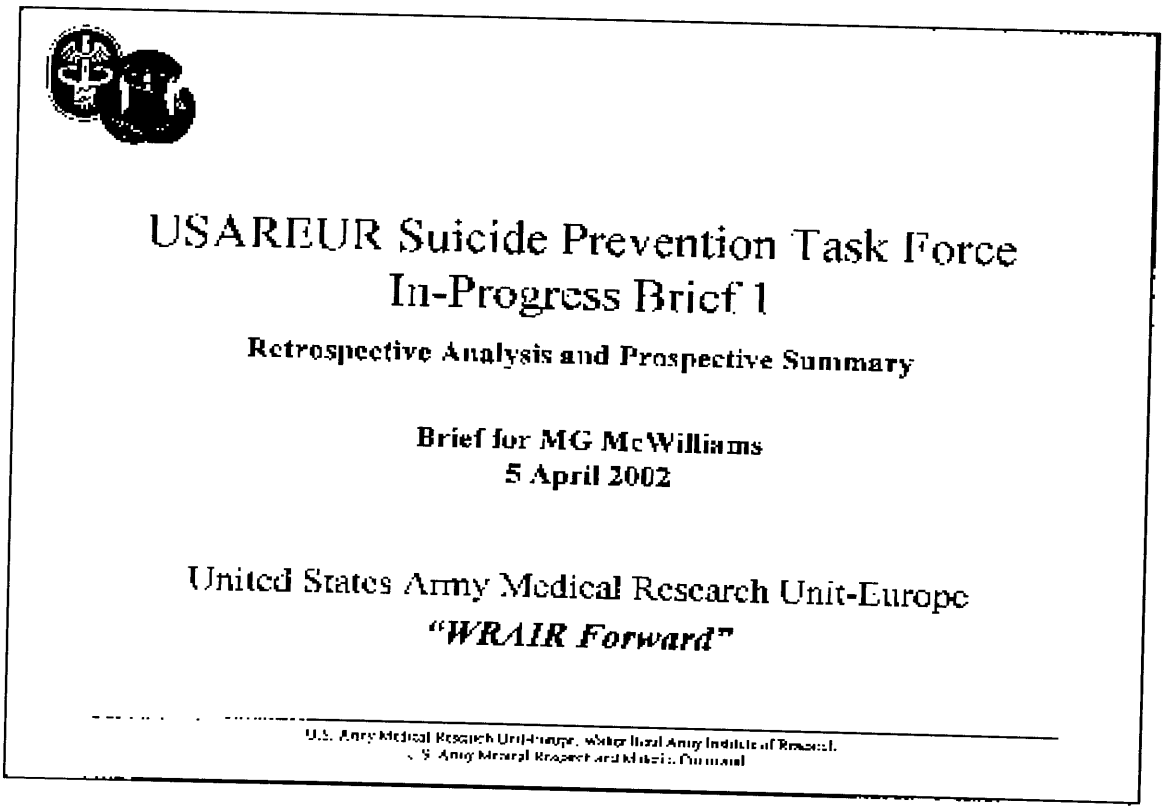
WHAT ARE THE BENEFITS OF COLLECTING INFORMATION ON ATTEMPTS? What can you possibly learn from that? I don't see any value in that. For any number of reasons, suppose that you find that the vast majority of suicide attempters are white or black, so. What does that tell you? Nothing. Suppose you find out that 80% had financial trouble. Does that tell you anything? No, that doesn't tell you anything clinical about what to do and what not to do. So that's what I'm saying. I don't think this adds anything. One of the problems with some of the some of the studies that have a gun to psychiatry that they arrive at conclusions that are analogous to that people who are Scandinavian and blue eyed, blond hair have the highest incidence of pernicious anemia, which is true. Then they extrapolate and say that therefore any Scandinavian person who has blue eyes and blond hair has pernicious anemia, which is not true. But unfortunately those are the kinds of conclusions that can be draw from this kind study. Suppose you find that there a cluster of 3 of the 5 suicide attempts in the Wiesbaden area. Does that tell you anything that you can do anything about? No, it doesn't. I don't know what the value is. I'm speaking vary frankly about this.

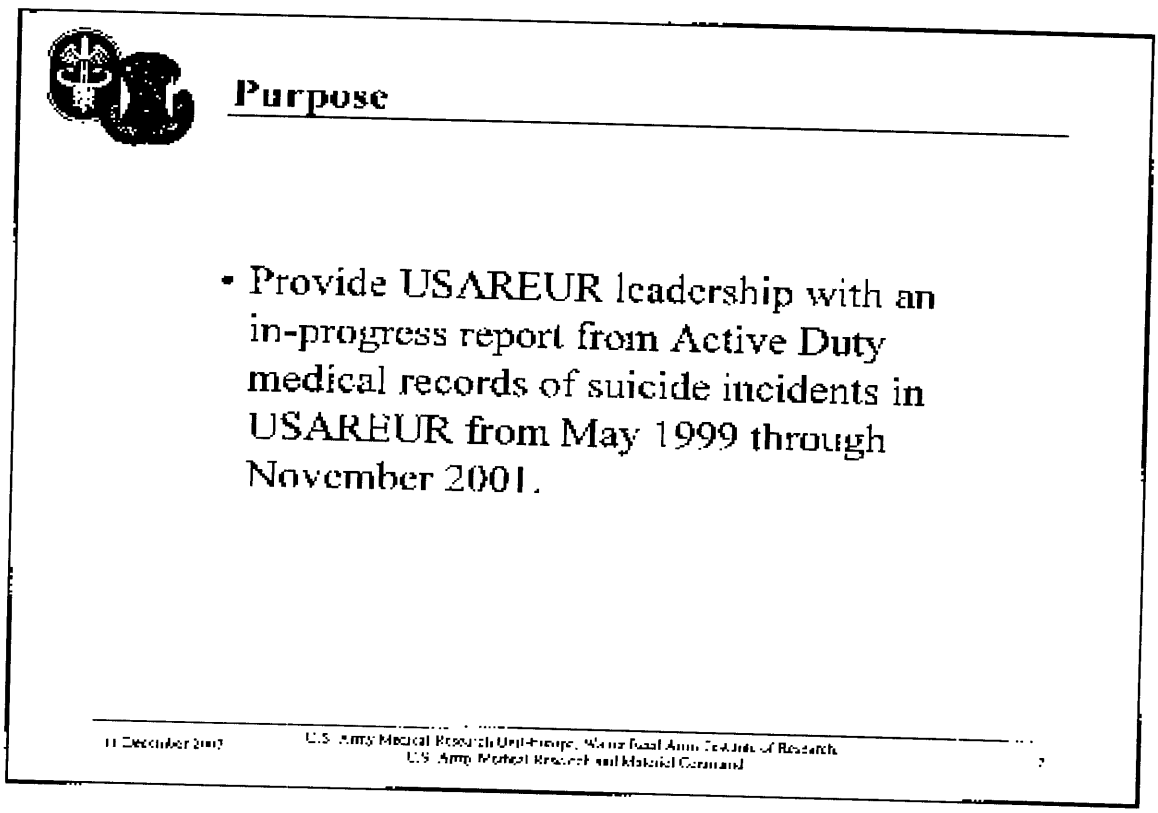
Appendix H – Transcripts of Clinical Provider Interviews cont.

If it was severe enough that the person was hospitalized. It will not be for just the wrist scratchier that you see in the emergency room. Well, it may provide some info Army wide, time will tell. Thought has gone into this and how to collate the events. You have to understand that form right there was the initial form of this.

I think that the one big advantage that this form [revised form] has over that one [7 page form] is the narrative. Where you have a chance to say things and come up with some sensible narrative that that form doesn't allow. Most of these will be filled out on the psych autopsy but you have the opportunity to write why the solder chose to injure themselves, it doesn't have to be kill themselves. To me that is one of the major pluses. As I understand the instructions from the ERMC DDCS. In Europe we're going to continue to do that form [7 page] instead of this [revised form].

Appendix I – Briefing to MG McWilliams



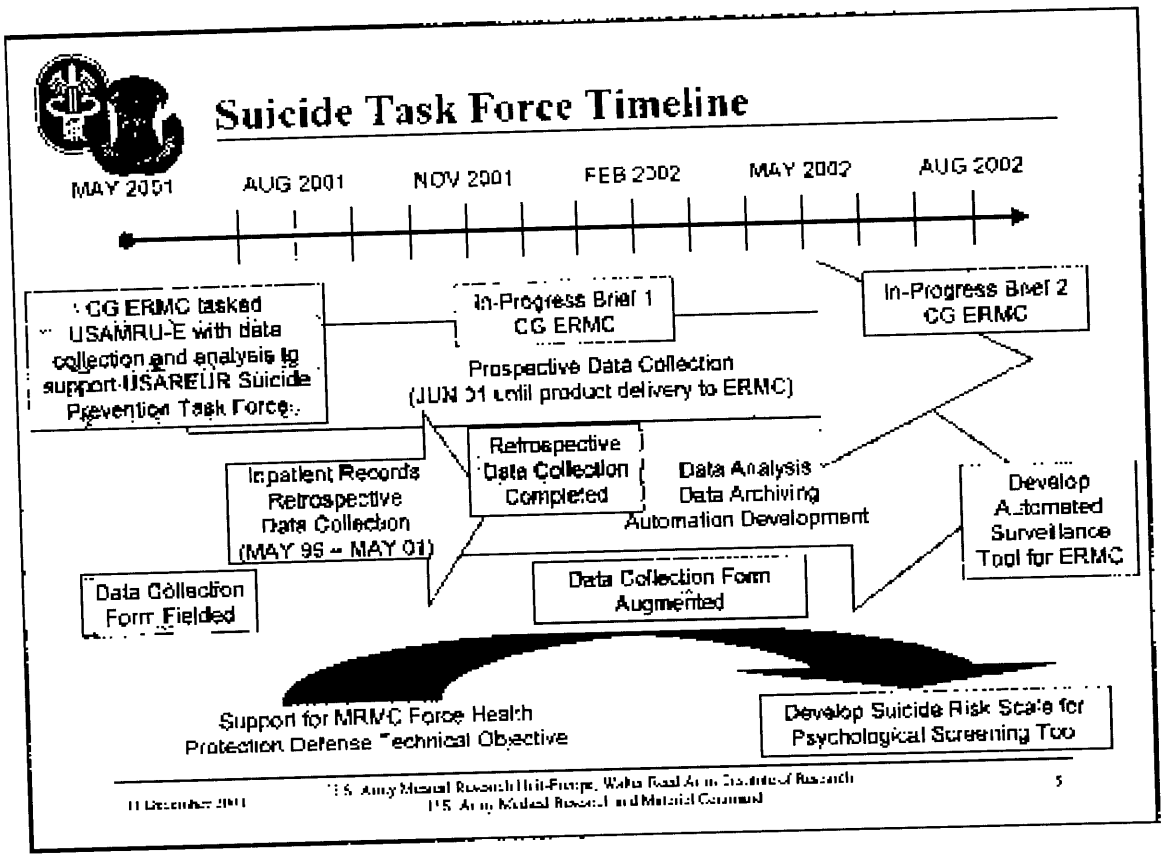


Principal Findings

- This report is based on 304 Active Duty Army, non-fatal suicide incidents in USAREUR from May 1999 through November 2001.
- Estimates of the relative risk of non-fatal suicide incidents show that these incidents are low probability events in USAREUR.
- Rank-related trend shows higher incidence rates of non-fatal suicide incidents for junior enlisted soldiers than for NCOs.
- The incidence rate for female soldiers was twice that of males. The finding is less than the gender difference reported in the literature.
- The September – November 01 data do not indicate any major departures from trends in the previous two years.

Outline

- Timeline
- Retrospective data analysis
  May 1999 through May 2001
- Prospective data summary
  June 2001 through November 2001
- Future Analysis Plans


Suicide Task Force Timeline
MAY 2001
AUG 2001
NOV 2001
FEB 2002
MAY 2002
AUG 2002
CG ERMC tasked USAMRU-E with data collection and analysis to support USAREUR Suicide Prevention Task Force
In-Progress Brief 1 CG ERMC
In-Progress Brief 2 CG ERMC
Prospective Data Collection (JUN 01 until product delivery to ERMC)
Retrospective Data Collection Completed
Inpatient Records Retrospective Data Collection (MAY 99 – MAY 01)
Data Analysis Data Archiving Automation Development
Develop Automated Surveillance Tool for ERMC
Data Collection Form Fielded
Data Collection Form Augmented
Support for MRMC Force Health Protection Defense Technical Objective
Develop Suicide Risk Scale for Psychological Screening Too
11 December 2001
U.S. Army Medical Research Unit-Europe, Walter Reed Army Institute of Research
U.S. Army Medical Research and Materiel Command
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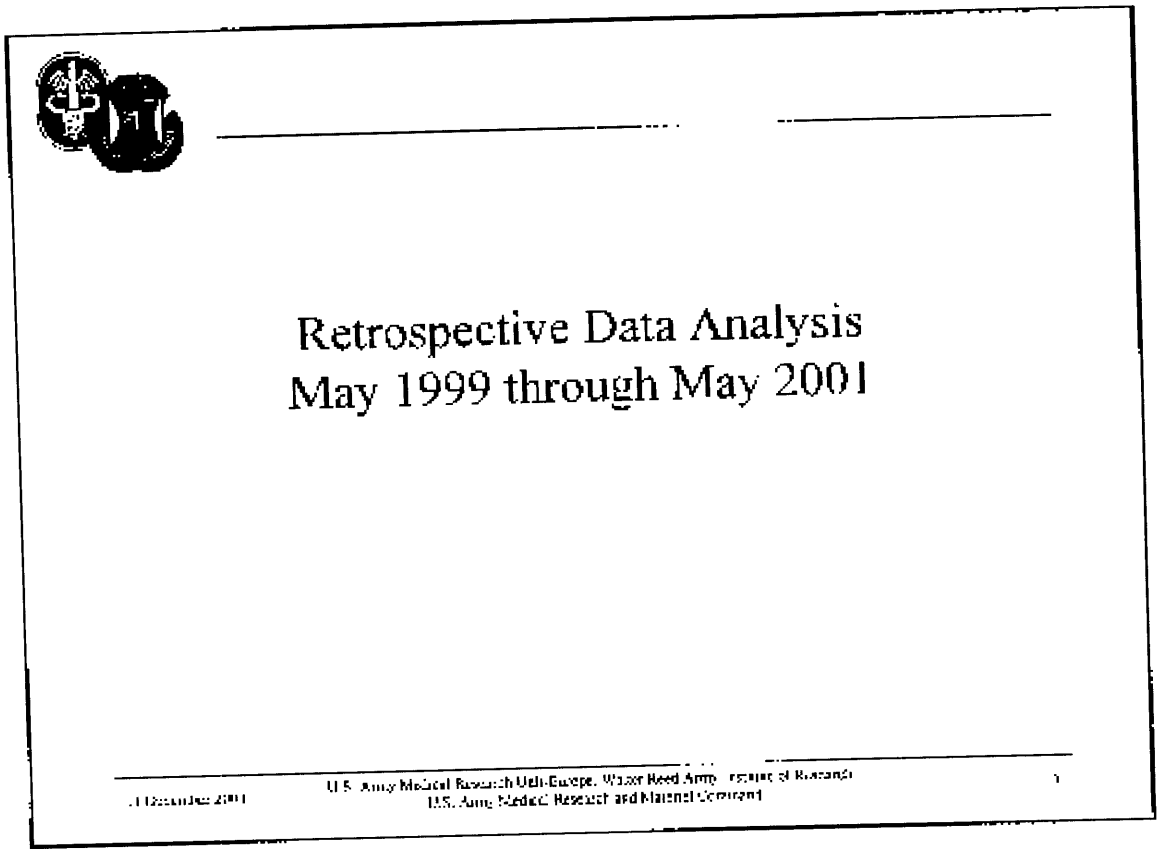
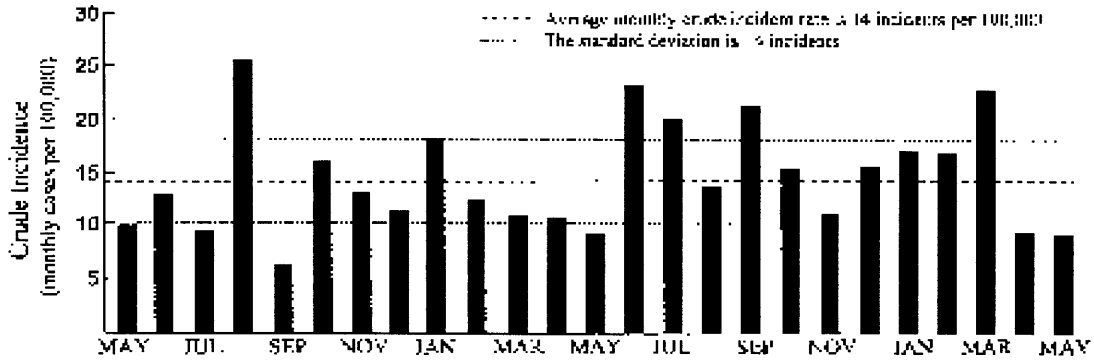

Retrospective Data Analysis
May 1999 through May 2001
11 December 2001
U.S. Army Medical Research Unit-Europe, Walter Reed Army Institute of Research
U.S. Army Medical Research and Materiel Command

Method

- Data collected from archived inpatient medical records, May 1999 through May 2001.
- An incident is defined as a non-fatal, self-injurious event ranging in severity, method, and degree of intent to commit suicide.
- Crude incidence rates are reported as number of incidents per soldier month.
- The crude incidence rate controls for differences in sample size across subgroups for making comparisons within a demographic category of a particular population.

Retrospective Monthly Incidence Rates MAY 99 through MAY 01



- A total of 221 active duty Army suicide events were in the archived inpatient records for the period May 1999 through May 2001.
- A crude incidence rate of 10 represents approximately 6 reported events.
- Inferences about seasonal cycles cannot be made since the relative contribution of demographic and other factors (PCS, deployment, turbulence in Theater) are not accounted for

Retrospective Data Demographic Summary

- Retrospective data included 221 Active Duty Army suicide incidents that occurred in USAREUR from May 1999 through May 2001.

Demographic Summary

Rank: 85% E1-E4, 13% E5-E9, 1% Officer

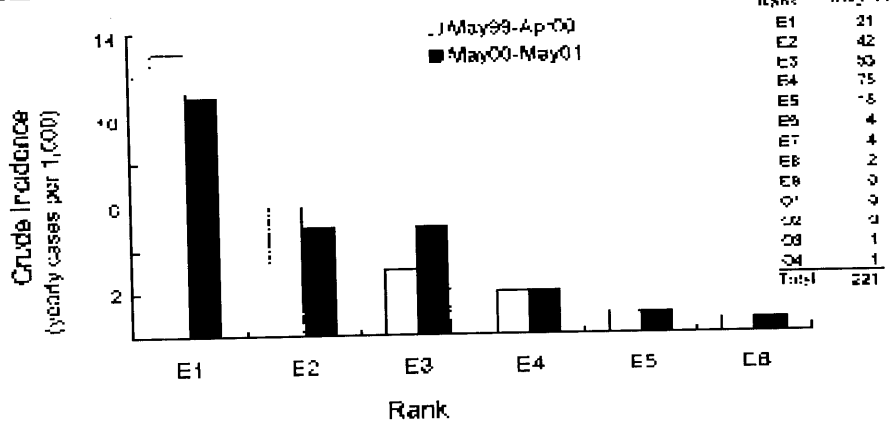
Age: 70% <25 years old; 21% 25-30 years old; 9% >30 years old

Gender: 72% Male; 28% Female

Racial Group: 61% White; 26% Black, 5% Hispanic, 4% Asian; 1% Native American; 1% Other; 2% Unknown

Marital Status: 45% Single; 42% Married; 7% Divorced; 1% Legally Separated; 5% Unknown

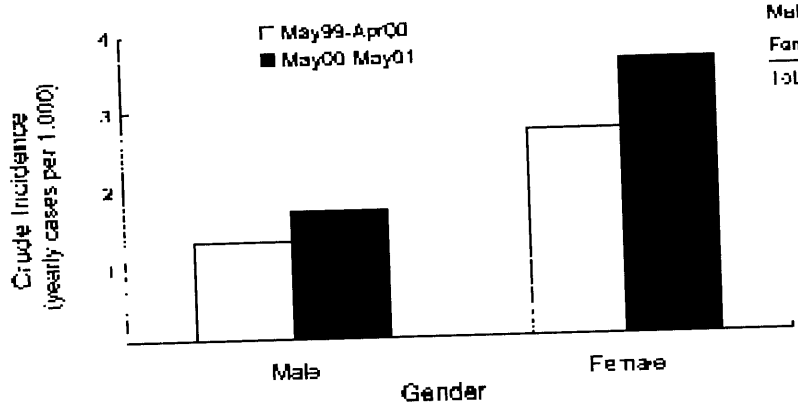
Incidence Rates by Rank



Rank	Incidents May '99-'01
E1	21
E2	42
E3	50
E4	75
E5	28
E6	4
E7	4
E8	2
E9	0
O1	0
O2	0
O3	1
O4	1
Total	221

- Rank-related trend shows higher incidence rates for junior-enlisted soldiers with statistical break at E4 between higher than expected rates and lower than expected rates.
- The decreasing incidence trend across rank for enlisted soldiers is consistent with age-related trends reported in the literature

Incidence Rates by Gender



Gender	Incidents May 99-01
Male	159
Female	62
Total	221

- The probability of an incident for female soldiers in USAREUR is 2 times that of males.
- In the general population, the probability of an incident for women is 3 to 4 times that of men.

Retrospective Data: Context & Risk Factors

- Contextual and risk factors are summarized from information collected from inpatient medical records.

Method: 58% (Overdose) 27% Cutting, 6% Other, 9% Multiple Methods

Medical Severity: 31% Mild, 19% Moderate, 5% Severe, 10% None, 5% Unknown

Victim's Intent: 33% Mild, 11% Moderate, 15% Severe, 11% Unknown

Duty Environment: 88% (Garrison) 9% Deployed, 3% Training

Prior History of Attempts: 57% (None) 32% prior history (13% attempted in the past year); 11% Unknown.

Communicated Intent: 20% None; 18% Friend/Coworker, 7% Family, 15% Other, 40% Unknown

Resides with: 24% Alone; 20% Spouse or children; 2% Barracks Roommate; 4% Other; 50% Unknown

Location of Event: 25% Barracks, 11% Personal Residence, 12% Other, 50% Unknown

Time in Country: 35% in country 1 year or less

Life Problems: (Relationship) and (work) were the predominant life problems reported, with the majority occurring within 3 months of the suicide event.

Clinical Diagnoses: Alcohol Abuse, Personality Disorder, Adjustment Disorder, and Major Depressive Disorder were the predominant diagnoses.

( ) = Findings consistent with Prospective data.

Prospective Data Summary
June through November 2001

Prospective Data: Method

- Prospective data were collected on 83 Active Duty Army inpatient and outpatient cases with information completed by physicians using the SPTF Form.
- The completed form is sent to USAMRU-E for archiving and analysis within 72 hours of the event.
- Incidence rates could not be computed at the time of this report. PERSCOM reports monthly strength numbers with an approximate lag time of six months.

Prospective Incidents: JUN through NOV 01

	JUN	JUL	AUG	SEP	OCT	NOV
Incidents	14	13	10	14	16	16

Prospective Data Demographic Summary

Demographic Summary

Rank: 86% E1-E4; 14% E5-E9

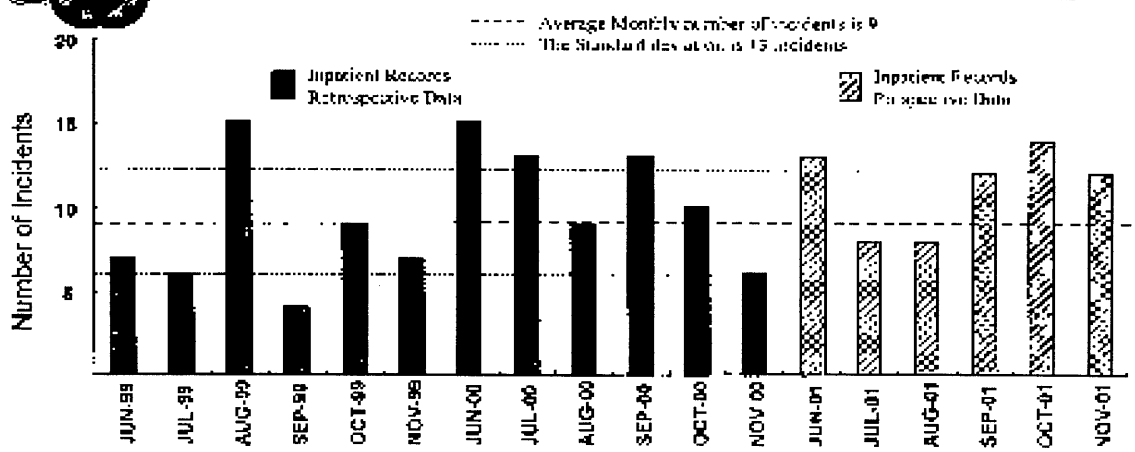
Age: 72% <25 years old; 17% 25-30 years old; 11% >30 years old

Gender: 65% Male; 35% Female

Racial Group: 65% White; 23% Black; 8% Hispanic; 2% Native American; 1% Asian; 1% Unknown

Marital Status: 59% Single; 35% Married; 4% Divorced; 2% Legally Separated

Retrospective and Prospective Incidents (JUN-NOV)



- The prospective data do not indicate any major departures from the monthly average.
- Raw numbers are reasonable for this monthly comparison because personnel strength numbers from June-November in 1999 & 2000 reveal a maximum monthly fluctuation of about 3% about a monthly average of 62,000 Active Duty soldiers.

Prospective Data: Contextual and Risk Factors

- Contextual and risk factors are summarized from information collected from inpatient medical records.

Method: 57% (Overdose); 29% Cutting/Piercing; 10% Other; 4% Multiple Methods

Medical Severity: 36% Mild; 46% Moderate; 8% Severe; 6% None; 4% Unknown

Victim's Intent: 30% Mild; 39% Moderate; 23% Severe; 8% Unknown

Duty Environment: 94% (Garrison); 5% Deployed; 1% Training

Prior History of Attempts: 57% (None) 37% prior history (17% attempted in the past year); 6% Unknown

Communicated Intent: 48% (None) 21% Friend/Coworker; 6% Family; 18% Other; 7% Unknown

Resides with: 57% (Live Alone); 18% Spouse or children; 6% Barracks Roommate; 10% Other; 9% Unknown

Location of Event: 53% (Barracks); 16% Personal Residence; 18% Other; 13% Unknown

Life Problems: (Relationship) and (work) were the predominant life problems reported, with the majority occurring within 3 months of the suicide event

Clinical Diagnoses: Alcohol Abuse and Personality Disorder were the predominant diagnoses.

( ) = findings consistent with Retrospective data.

SPTF Reporting: Future Plans

- Program Review
  - More informative Etiology Data
  - Break out Risk Factors from Triggering Events
- Revisit Subject Identifiers
  - Required to link with Health Utilization Database CHPPM
  - Required to link with Defense Manpower Database Center
- Implement Case Control Study
- Develop Automated Data Entry Tool as Physician's Note.
- Model Results for the Purpose of Developing a Real-Time Tool to Identify Changes in Incidence Trends.

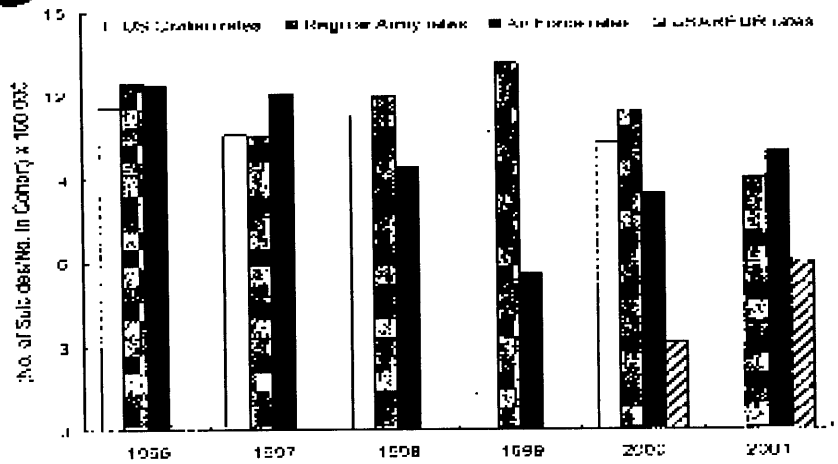
Point of Contact

MAJ James W. Ness
ATTN: Medical Research Unit
CMR 442
APO AE 09042-1050

DSN: 371-2626
COM: +49 6221 172626
FAX: +49 6221 173170
EMAIL: james.ness@hbg.amedd.army.mil

Prepared by: CPT Jeffrey L. Thomas, Ph.D., Kathleen M. Wright, Ph.D., & MAJ James W. Ness
Technical Staff: Erica Schroeder, SPC Kaisha Hang, Sandra Kelley, & Kara Godinneaux

Suicide Completion Rates from 1996-2001



- The Air Force implemented a suicide prevention program in 1999
- US Civilian rates not yet available for 2001
- 2001 USAREUR rates estimated from partial strength figures